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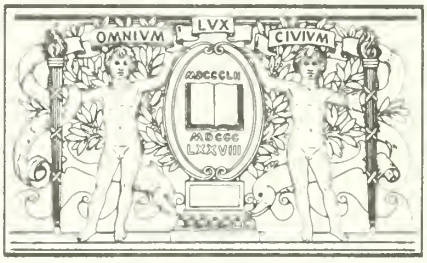

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MORE THAN SHELTER: A COMMUNITY RESPONSE TO HOMELESSNESS

REPORT
AND RECOMMENDATIONS

UNITED COMMUNITY PLANNING CORPORATION
MASSACHUSETTS ASSOCIATION FOR MENTAL HEALTH

MORE THAN SHELTER:
A Community Response to Homelessness

Report and Recommendations
of the project
"Homelessness: Organizing A Community Response"

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PREFACE

This report and its recommendations are a product of a project called "Homelessness: Organizing a Community Response." The project was conducted by the Massachusetts Association for Mental Health and United Community Planning Corporation as part of their long-term involvement with various aspects of homelessness and related issues.

Both organizations decided that, although people were concerned with the homeless, little comprehensive information was available on this part of the community. This report documents, to the extent possible, and further analyzes the characteristics of the current homeless population in the Boston area. It also examines the social service network intended to serve the homeless and makes a series of recommendations to improve the system.

We hope that this report will facilitate tangible improvements in the individual lives of the homeless in the Boston area.

ACKNOWLEDGMENTS

We would like to express our gratitude to the many people who contributed to making this report possible. More than forty people served on the project Advisory Committee and two Task Forces. Over 120 people were interviewed or provided information in some fashion. These people along with many shelter staff, advocates for the homeless, and community activists all greatly extended themselves and helped us finally write this report.

We also wish to thank the trustees and staff of the four foundations who provided financial support for this project. The foundations are the Harriet B. Bayley Trust, the Godfrey M. Hyams Trust, the Arthur D. Little Foundation, and the Riley Foundation. Leaders of these organizations as well as others within the philanthropic community of Greater Boston are deeply concerned with the problem of homelessness. We appreciate their recognition of the importance of basic research and a planned approach to the development of new programs.

Throughout the development of this report the continued support and involvement of the project Advisory Committee and its two Task Forces has been invaluable. The two Co-chairs of the Advisory Committee, John Bok and William Kantar, M.D., were extremely generous with their time and expertise. David Whitty and Ellen Bassuk, M.D. who chaired the two Task Forces also deserve special mention for their respective roles in this project.

Our appreciation finally goes to the many staff members of United Community Planning Corporation and the Massachusetts Association for Mental Health who have helped us along the way. As our two agencies cooperated in the preparation of this report nearly every staff member became involved to some extent in the project. To all of them go our hearty thanks. In particular we wish to thank Paul Hunt and Mary Kassler who, representing UCPC and MAMH respectively, kept the financial details in order and provided a useful perspective on a host of substantive issues.

We also wish to thank Cheryl Gordon, who coped patiently and skillfully with all our many textual changes and Virginia Trainer who, while editing this report, displayed remarkable sensitivity to the complex human problems which we have tried so hard to explain.

P.M. and A.S.L.

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INTRODUCTION

I. THE ISSUES

On a cold night there are more than one thousand homeless adult men and women sheltered in various emergency accommodations in Boston and Cambridge. They are part of a larger number of individuals who are poor and homeless. The data in this report show that a very large percentage of these people have serious problems or are chronically ill. None are homeless because they prefer this way of life. Adversity of some type leads to their plight. Major mental illness, alcoholism and various other medical or psychological problems are facts of life for most.

On the same night, over eighty families are provided for in sheltering accommodations. Like the individuals, these families are poor and homeless. They, too, are part of a much larger number of families who may be doubled up or living untenably with relatives or friends but who are in reality homeless. For these families, there is a crisis in real estate: It is all but impossible to find vacant and decent housing in the cities of Boston and Cambridge for low-income couples or individuals with one or more children.

The service needs of the individuals and families are many and varied, but these needs can be described in two categories. The first and most immediate needs are elemental: stability, some food and a safe place to sleep. In this report, these fundamentals are termed "survival services". Beyond the survival services, the needs are longer term and often profound. These include opportunities for stable and appropriate housing which must offer, for a very large portion of the homeless, the care and supports needed by a chronically ill population; adequate financial supports for many who cannot participate in the traditional employment market; stable and humane medical and psychiatric care; and opportunities to feel part of a community, to feel that one belongs.

For some, even the survival services are unmet needs. Some individuals or families are turned away at the shelters for lack of space. Others do not seek help and "make do" in the streets, in abandoned buildings, or in cars. The homeless population is much larger in number than those actually receiving the survival services.

Becoming homeless -- no longer having a place to rest in privacy, prepare one's food, care for one's children, and store one's goods -- is perhaps the most profound privation imaginable in our society. Moreover, to become homeless is extremely dangerous to body, mind, and spirit. There is danger of severe physical illness, injury

or death. Media coverage has made the public aware of the dangers of cold weather. Inevitably, each year men and women have been found frozen to death or have died in fires started to fight the cold. And, cold is by no means the only danger to health. A sample of any large shelter population includes persons with serious medical problems, including respiratory and cardiovascular difficulties that are exacerbated by the stress of street life. In addition to illness, the danger of violence is ever-present. Street people are frequently targets of assaults and victims in street fights. Inadequate care and protection often make the resulting bruises and wounds far more serious.

Most dangerous of all are the effects of the homeless experience on self-esteem and morale. For those who have difficulty functioning because of mental illness, living on the street is utterly inhumane and seems only to assure the most bleak long-term prognoses. Persons newly homeless become panic-stricken by the dual experiences of having no home (and all that that implies) and becoming non-persons in the eyes of society. For everyone, homelessness raises the spectre of life forever without the security and comforts that "home" (in all its variations) can provide.

It is the underlying premise of this report that homelessness is inhumane and thus, unacceptable and that society has an obligation to provide for the most needy individuals and families who cannot provide for themselves. For the homeless population, traditional social service networks have failed and personal support networks have collapsed. Shelters are an important first step to solutions which will be complex and, in all probability, expensive. Our findings re-affirm the need for the existing sheltering system and suggest that additional facilities need to be created to meet immediate needs. However, our interpretation of findings is based on a belief that shelters must be maintained as "time-limited" settings and that we need to address the nature of the problems and the underlying causes of homelessness.

We sense that the plight of the homeless has been exacerbated over the years by the public's desire to find a "deserving poor." The image of the "deserving poor" is that of persons who simply need a helping hand and then will be able to pull themselves out of poverty and to provide well for themselves thereafter. The majority of the homeless in Boston and Cambridge do not fit this image. In fact, the chronicity of illnesses and the nature of problems suggest a need for care that is intense and often long-term.

Despite the rules requiring daily or weekly departures, the shelter network has become a long-term solution for many. For some homeless people, the shelters have replaced the institutions which "warehoused" them in days past. For others, younger and uncared for, the shelters provide the only constant and dependable care they have known. However, for all of these persons -- dependent and in need of care -- the shelters are not appropriate over time. A constructive community response to homelessness must include much more. The longer-term needs of the population are stable and appropriate housing, adequate financial supports, humane medical and psychiatric care, and the opportunity to belong somewhere -- to have a home.

II. THE NEED FOR A COMMUNITY RESPONSE

A. Project Conception

During the autumn of 1981, staff and volunteers from the United Community Planning Corporation (UCPC) and the Massachusetts Association for Mental Health (MAMH) began discussing the possibility of cooperatively addressing the problems of homelessness in Greater Boston. Both agencies shared a deep concern for the problems faced by persons without homes and without resources to provide for themselves.

A proposal for funding was written and sent to Boston area foundations in the summer of 1982. Four foundations acted favorably on the request: Harriet K. Bayley Trust, Godfrey Hyams Trust, Mabel Louise Riley Foundation and Arthur D. Little Foundation. Research was carried out in the winter and spring of 1983 and this report was written during the summer of that year.

The project had two general goals: (1) To gather reliable data and information about the characteristics and needs of the homeless in selected areas of Greater Boston; and (2) To develop a coordinated approach to meeting the needs of the homeless population in Greater Boston with potential statewide application.

Under these general goals, there were more specific objectives. Reliable data about the homeless populations needed to answer the questions "Who are the homeless?" and "Why are these individuals and families homeless?" Developing a coordinated approach to meeting needs had to include understanding what services are currently available, who is making use of them, what services are not available and why they are not.

To meet these goals and objectives, we needed to collect information and data from a number of sources and in a number of ways. The research methodology included information gathering from (1) interviews throughout Greater Boston with shelter directors and directors of programs which provide services to homeless individuals and/or families; (2) a one-day census of homeless individuals and families in Boston and Cambridge, including the gathering of rudimentary personal information about those who were accommodated in shelters and basic statistical data about those who, on that day, were turned away; and (3) a series of in-depth clinical interviews with a sample homeless population, assessing personal characteristics and problems and providing specific diagnoses.

B. Methodology

1. Interviews with Shelter Directors

To gather information about resources available in the community, we conducted extensive interviews with shelter directors and directors (or appropriate contact persons) of programs which provide services to homeless individuals and families.

We used an eight-part questionnaire to gather the following kinds of information:

a. Baseline information - including daily schedule, capacity, rules, and intake procedures.

b. Nature of the organization - its age, number of staff and volunteers, type of board and sources of funding.

c. Numbers and characteristics of guests serviced by that shelter. Directors were asked to describe the clientele e.g., age, sex, mental health needs, alcoholic problems, and the proportion who were "regulars" on the streets. The shelter directors provided researchers with information about average numbers of persons using shelters over specified periods. We also asked directors to comment on the extent to which they thought recent economic events have impacted their clientele.

d. Shortfalls and turnaways - In an effort to define the unmet demand for emergency accommodations, we asked directors for any statistical data that might be kept on turnaways over longer periods of time. Researchers asked what alternatives the directors suggested to persons or families whom they could not accommodate and where they thought people using that shelter slept when no other accommodations could be found.

e. Blue sky questions to estimate the total number of beds thought to be necessary to accommodate all those currently homeless in Greater Boston and where those beds ought to be located.

f. Referral system - which agencies send people to the shelters and how the referral system might be improved.

g. Other services used by the shelters - medical care, detoxification programs, financial assistance, services for children. An attempt was made to assess how well the public and private non-profit programs were integrated and what services guests at shelters were and were not getting.

h. Rehousing and resettlement - To what extent does a shelter get involved in providing assistance to guests seeking permanent housing? Is there follow-up when referrals are made? What are the most effective techniques in helping guests locate housing? What are the chief obstacles and/or statutory impediments? How many persons or families have moved to permanent housing from the shelter during the past year? We also asked directors if they used any "transitional housing" programs.

The interview questionnaire for the referral agencies was similar to the one for the shelters except that agency personnel were asked to comment on the homeless individuals and families served in their non-sheltering functions. In a separate section on shelter needs, we asked agency directors or representatives how many people come to the agency in need of emergency shelter and where the agencies refer such people or families.

2. One-Day Census.

From the beginning of the project, an important objective was to determine the numbers of homeless. In order to plan services for the shelter population, the nature and extent of the problem of homelessness needed to be defined. To answer these questions, we designed the one-day/one-night census. We were not attempting a count of the people living "on the street" or the homeless temporarily housed with relatives or friends. The census was designed to gather information about the homeless population -- its size and general characteristics -- which on that particular day and night sought and/or received emergency help from the limited sheltering resources availble in the community.

a. Participants. We asked 27 public and private agencies to participate in the census. Some of these agencies provide shelter alone and some provide services as well.

The list of participating agencies in Boston and Cambridge included shelters for individuals, families, individuals and families, women in crisis; inpatient units at two state mental health facilities; and detoxification centers. Directors of the inpatient units and detoxification centers were asked to count only those persons who had no address and no place to go. Shelter directors were asked to count all persons who came through their doors that day looking for a place to sleep.

b. Selection of a Date. Concerned that we would not see all of the homeless population of Boston and Cambridge, staff at the shelters and agencies expressed concern that the day and night of the census be the right ones. However, we knew that, no matter what day we chose, some homeless people from Boston would be in the Bridgewater detoxification program, or in the Middlesex County Hospital, or a community-based program of one sort or another, or simply not showing up at the shelters. There was also concern about the weather on the day of the census - that it might not be as cold or snowy as another day. We simply had to accept this notion because the date had to be selected well in advance in order to get out the forms and organize the collection process.

The date chosen was Friday, February 25th. Every shelter and sheltering facility on our list received a letter describing the project and its goals, requesting help on the chosen day, and enclosing appropriate numbers of forms and return envelopes.

c. Designing the forms. We discussed the content of the census forms with the Advisory Committee in January. With their recommendations, we began discussing the forms with the shelter directors who would be administering the census. The directors greatly influenced the content of the forms. Both on questions of content and style, we felt that those who would be carrying out the census should guide the ultimate design of the forms. We were particularly concerned about the Pine Street Inn, the population of which would comprise better than 50% of our respondents. After we had established the categories of information we wanted to obtain (age, sex, frequency of shelter use, and some idea of the reason for homelessness), we sat with Pine Street shelter directors and designed the specific questions. The family forms were designed to pick up comparable information about families.

The questions for Pine Street were written in language the directors chose in order to expedite the process. With so many people coming in during a short period of time, the need for short and concise responses was essential to the success of the effort. The Pine Street form also included a specific question about its clinic instead of the more general question about major health problems.

3. Clinical Interviews.

Although the February census provided basic information about the homeless population, it was clear that our information lacked important specifics. While significant percentages of the population had been assessed by shelter directors as having "psychological problems" or as being "alcoholic," the extent and nature of those problems was unclear.

We also had no knowledge about services being received by the shelter population; about existing relationships with agencies or families; or about the appropriateness of recommending various new services e.g., housing, financial assistance, employment, or counseling. Although we could not get detailed information from the entire Boston-Cambridge population of homeless individuals, we decided we could get it from a representative sample.

The demographic and basic needs information obtained in the February 25 census indicated that the state-run shelter at the Lemuel Shattuck Hospital housed an overflow from the other area shelters. Further, the demographics at Shattuck Shelter reflected the overall demographics of homeless adult individuals in Boston and Cambridge. The size of the shelter, in addition, made it the most logical place to conduct a series of interviews.

We received approval for conducting a clinical evaluation of guests at the Shattuck Shelter from the Shattuck Hospital Review Board on April 25, 1983 and began interviewing on the same evening.

A team of nine experienced mental health professionals (five psychiatrists, two psychologists, two social workers) interviewed 78 homeless men, women and children. Because the weather was warm during the days and evenings of the study and because the dates coincided with the end of the month (and for some with the receipt of financial assistance checks), the number of people at the shelter was somewhat smaller than usual. The team interviewed all available guests.

Prior to beginning the interview, the survey was described to each guest who then signed a consent form. Confidentiality of responses was assured. At the end of each interview, the clinician completed a questionnaire that included demographic and clinical variables; the Brief Psychiatric Rating Scale (BPRS), which assesses the severity of various symptoms; the Global Assessment Scale (GAS), which assesses the degree of functional impairment; and standard psychiatric diagnoses from the Diagnostic Statistical Manual. The information was coded, computerized, and analyzed by clinicans and researchers for use in this project.

PART ONE

THE EXISTING SHELTER SYSTEM AND RECOMMENDATIONS FOR FUTURE DEVELOPMENT

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THE EXISTING SHELTER SYSTEM AND RECOMMENDATIONS FOR FUTURE DEVELOPMENT

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I. THE EXISTING SHELTER SYSTEM -- HISTORICAL BACKGROUND

In 1675 King Philip's war occurred in Massachusetts. King Philip was an Indian who led a major revolt against the white colonists. While ultimately unsuccessful, this Indian rebellion caused panic among the frontier families, many of whom abandoned their homes and fled to Boston. Soon Boston was filled with families who were homeless and destitute. The provincial government responded to their urgent pleas for assistance by accepting responsibility for their welfare. Food and funds were provided until the danger was past and they could return to their homes. From then until now the government of this Commonwealth has often had to respond to the needs of poor people with no place to go.[1/]

The decision made by the provincial government in 1675 was significant because it recognized that existing arrangements for the relief of poor people were not sufficient to meet the overwhelming needs of the displaced families. In Boston, as in the other towns of the province, it was traditionally understood that each local government was responsible for the needs of the poor in their own communities. Towns vested in a single individual or in special committees the authority to deal with these cases. Both the legal framework and the administrative arrangements were modeled upon English law and practice.

This English model was based upon an assumption that virtually all persons lived with their own families and within the bounds of some governmental jurisdiction. The expectation was that "relief" would be granted primarily to such families as a whole. Provision of relief to adults who wandered through the countryside or city streets without a permanent home and without family ties was not envisioned.

Yet in England, and later in America, the phenomenon of the wandering homeless person -- often called the "unsettled poor" in older treatises on welfare law -- arose to trouble local officials. In Massachusetts, an administrative and legal structure was developed which assigned to local governments the responsibility for the care of all persons who were "settled" in some community while allocating to the Commonwealth responsibility for the relatively small number of "unsettled."

1/ National Study Service Report, Meeting the Problems of People in Massachusetts, Massachusetts Committee on Children & Youth, 1966, p.3.

Local officials tended to provide "relief" through grants of money or by purchasing food and fuel. In larger communities, and in Boston particularly, this system came under increasing strain during the early nineteenth century. Local governments developed facilities called "almshouses" or "workhouses" which served as more or less permanent residences for homeless men and women. Jails were also used to house single unemployed men.

In 1854 the Commonwealth established a State Almshouse in Tewksbury. In 1866 a State Workhouse, which was considered a penal institution, was established at Bridgewater. The following description, written in 1886, described their functions:

> "Poor persons, not having known settlement in the State, and neither too ill nor violently insane, may be sent to the State Alsmhouse by local authorities. Some of them are transferred to the pauper department (300 beds) of the State Workhouse in Bridgewater. Officers of the State Board of Health, Lunacy and Charity may prosecute vagrants, drunkards, etc., who are inmates of the State Almshouse to secure their commitment to the State Workhouse. Insane paupers may be transferred to the Insane Department or to a State Lunatic Hospital by the State Board, upon a proper medical certificate."2/

In Massachusetts, and in the nation generally, a double system of "poor relief" had evolved. On the one hand, money, food and other necessities of life were provided to persons living in their own homes. On the other, unsettled poor people were housed in facilities set aside for that purpose.

Meanwhile a separate set of programs emerged which were organized and funded by associations of private persons and which today we would call "non-profit agencies." These private programs were developed, in part, because of a conviction that the public "system" was both inhumane and wasteful. Nevertheless, these private organizations established a double set of programs which were similar in intent to those of the public sector.

2/ The Associated Charities - A Directory of the Charitable and Beneficient Organizations of Boston, Boston, MA, 1914, p.111.

Provision was made for the poor living in their own homes. The following description of the Roxbury Charitable Society, founded in 1799, provides the atmosphere of what we today call a community-based multi-service agency:

> "Gives money, food, fuel and clothing to the destitute of good character and living in Roxbury. In the Society wood-yard men work for aid rendered. Sends applicants to a physician, or a physician to a patient at his home, when necessary. Certain foods for the sick are given on orders from attending physicians."3/

On the other hand, private organizations developed "Homes" which specialized in the care of one or another category of person. Primarily they served the elderly or the young. In Boston, several were dedicated to the welfare of homeless "seamen" or "mariners" who ordinarily had not accumulated much money and, as they grew older, found little employment. In 1837, "The Mariners' House" was established as "a temperance home free to the shipwrecked and distressed where seamen can board at reasonable terms."4/

Jane Smithers, in her unpublished study of homelessness, points out that in the late nineteenth century economic upheaval such as the panics of 1873 and 1893 sent many thousands of unsettled men on the road looking for work and caused great concern among welfare administrators across the land.5/ With the eventual passage of the federal Social Security Act of 1935, localities no longer needed to support elderly residents or mothers with minor children. In Massachusetts, however, local Boards of Welfare still administered the program called "General Relief" until the State Legislature reorganized the entire public welfare system in 1967. At that time General Relief became a state-funded and state-administered program of cash assistance for individuals.

During the early part of the twentieth century, most of the workhouses and almshouses operated by local and state government were slowly phased out. The benefits provided through various public welfare programs, including General Relief, were believed sufficient to allow poor individuals and families to pay for their own lodgings and food. Direct housing of the poor was seen to be the responsibility of the various public housing authorities which emerged during the 1930's as another federally sponsored initiative. Only persons who were physically or mentally ill were seen to be in need of housing and protection which was then provided as part of some type of therapeutic program, such as a mental hospital or nursing home.

3/ Ibid., p.37.
4/ Ibid., p.15.
5/ Smithers, Jane, Sociological Theory and the Problem of Homelessness: A Reconsideration, Unpublished Paper, Boston University Department of Sociology, 1982, pp.36-40.

It should be noted that in Massachusetts there were a few exceptions to this pattern. Some cities continued to operate "Homes" but only for destitute elderly persons who had been residents of the community. The Commonwealth continued to administer two Soldiers' Homes for elderly veterans in Holyoke and Chelsea, and the City of Boston continued to operate a shelter for women and children on Chardon Street, as it had done since 1859. The Department of Public Welfare operated a homeless persons unit on Hawkins Street in Boston. In the late 1960's, the Department also began to support Pine Street Inn financially. In general , however, the direct provision of emergency housing, food and protection to very poor people became less and less a public responsibility as the twentieth century progressed.

II. THE MODERN SHELTER MOVEMENT

During the nineteenth century, private charity in America was responsible for the development of many residential services for the elderly and the young. However, private charity was less likely to sponsor sheltering programs for adults in the "productive years" over 18 and under 65. The sheltering programs which did begin served adults afflicted with a handicap such as blindness, deafness or mental retardation. In the later part of the nineteenth century, the growing temperence movement sponsored a number of residential programs for alcoholic men and women who had to promise to stay abstinent in order to obtain shelter.

As concern with alcoholism increased, the Salvation Army and other church-related organizations began to establish "missions" in those parts of major cities where drunkeness was commonplace. Some of these missions evolved into programs which we would today recognize as "shelters." In them, homeless men would be sheltered even if they did not remain abstinent.

In 1916, a group of Protestant clergymen initiated such a facility, called the Rufus Dawes Hotel. Located on Warrenton Street, it provided about 200 beds for homeless men. After several changes in location and reincorporation, it became what we now know as the Pine Street Inn.

An inventory of services available for homeless men in Boston was prepared in 1961 for Action for Boston Community Development. In addition to the Dawes Hotel, the report described one operated by the Salvation Army (148 beds) and another sponsored by Morgan Memorial (60 beds). At that time there were no shelter services for homeless women or families except those provided by the City of Boston at Chardon Street.[6/]

New shelters began to appear in the Greater Boston area in 1972. The chart below lists 21 with their dates of opening.

1972 - Sancta Maria
1974 - Shelter, Inc., Rosie's Place, Elizabeth Stone House
1975 - Casa Myrna Vasquez, Roxbury Corps Center, Respond
1976 - Transition House

6/ Harold Demone and Edward Blacker, The Unsettled and Socially Isolated Residents of Skid Row, Action for Boston Community Development, Boston, MA, 1961, pp. 34-43.

1979 - Emergency Services Center CASPAR, DOVE
1980 - Parker Street (Lindemann), Renewal House
1981 - Sojourner House
1982 - Commonlife, Waltham Battered Women's Shelter, Project Hope, Womensplace
1983 - Shattuck Hospital, Long Island Hospital, Shelter, Inc., Boston Family Shelter

With four public sector exceptions (Emergency Services Center CASPAR, Parker Street, Shattuck Hospital and Long Island Hospital), the development of these shelters has been initiated by groups of private citizens who were intensely concerned about the needs of a specific population of homeless persons who share common characteristics or who congregate in a specific geographic location.

These "core groups" tend to have coalesced around some issue larger than the "need for shelter." For example, the founders of Rosie's Place felt an intense commitment to serve homeless women who, they believed, were being ignored by all the other agencies. Among this core group, knowledge of street women as individuals and knowledge of the danger of life on the street led to the conclusion that some type of home-like shelter was an immediate need. However, the group felt that far more than a shelter was needed and that the shelter could serve as a base from which to advocate more effectively for the needs of homeless women.

Several of the shelters for battered women developed in a similar fashion. The core group was typically composed of women who had themselves experienced abuse and who banded together, at first, not to begin a sheltering program but to help one another by providing emotional support and practical help. Having developed a high level of mutual support and trust, these groups then began to plan shelters to meet the needs in their localities. However, a shelter was always seen as just one aspect of a more general effort to help battered women.

As these various sheltering programs grew, they began to seek reliable sources of funding, including public funding. The Department of Public Welfare and Pine Street Inn reached an agreement which allowed the Department to provide funds in support of Pine Street from the General Relief budget. At a later date a similar agreement was reached with Shelter, Inc. Meanwhile, battered women's shelters obtained financial support first from the Department of Public Welfare and then, after reorganization, from the Department of Social Services.

The founders of CASPAR, an integrated program for alcoholics in the Cambridge-Somerville area, had a basic plan for a shelter in Central Square for almost ten years before funding became available. In the beginning it was primarily supported with Federal funds available through the Public Inebriate Program.

In 1980, the then Commissioner of Mental Health authorized the development of the Parker Street shelter to provide survival services to homeless mentally ill persons. Developed with the cooperation of Pine Street Inn, it primarily has served guests from that facility and Rosie's Place. The subsequent history of the Parker Street shelter, once closed and then reopened as a result of an outcry raised by the shelter community, is well known. It was and is staffed by state personnel and supported entirely by state funds.

III. THE PUBLIC SECTOR RESPONSE TO HOMELESSNESS IN 1983

When Governor Michael Dukakis took office in January of 1983, he announced that his administration would make the problems of homeless persons and families its number one priority. Soon after, acting through his Office of Human Resources, he created the Governor's Advisory Committee on Homelessness, chaired by Kitty Dukakis and Bishop Harrington of Worcester.

The Governor's decision had been conditioned by many factors including the national recession, sharp cuts in human service programs by the Federal government, and the critical shortage of low-cost housing in the Commonwealth. Of great importance was the fact that the Massachusetts Coalition for the Homeless, which had been formed in late 1981 and had embraced a wide variety of sheltering organizations, community agencies and advocacy groups throughout the state, had aggressively urged the Governor to take action on the problem of homelessness early in his administration.

This Advisory Committee has served as a rallying point for all of those concerned with homelessness. Task Forces on Housing, Emergency Responses, Private Sector Initiatives, Deinstitutionalization, Medical Needs, and Cash Assistance, were created. Members of these task forces prepared a multitude of white papers and reports to the Governor during the Spring of 1983.

One of the major activities of the Governor's Office of Human Resources was the development of twenty-five local groups representing private and public agencies, church groups and shelter or meals providers. These groups have provided the Governor with a great deal of information about the types of homeless populations found in various parts of the state.

One result of the Governor's initiative has been the awarding of a dozen grants by the State Department of Public Welfare to private non-profit agencies who will be opening new shelters or expanding old ones. These grants will support 75% of operating costs for designated shelters in their first year of operation. In the second and succeeding years a commitment has been made to provide 50% of operating costs.

In 1983, the Department of Public Health, with the active cooperation and support of Governor Dukakis, opened a shelter for homeless individuals and families at Shattuck Hospital. At about the same time, the City of Boston opened the Tobin

Building at Long Island Hospital for use as a shelter for persons bussed from the South End. These initiatives by state and city government marked an assumption of direct responsibility for the care of homeless persons which was a departure from the policies of the recent past, but a return to former policies.

The Fiscal Year 1984 budget, submitted to the Legislature in January of 1983, contained funds for the operating costs of several shelters and also increased amounts for emergency assistance, rental assistance and fuel assistance. Funds were also requested for a reserve account to support other projects for the homeless. While some of these items were cut back or eliminated by the Legislature, these steps were supported by advocates and providers for the homeless.

Meanwhile, the City of Boston was also mobilizing to meet the needs of the homeless. In the spring of 1983, the Mayor and City Council cooperated in the creation of an Emergency Shelter Commission. Chaired by Sister Barbara Whelan, Director of Bridge Over Troubled Waters, it has developed a program of activities by city departments which are helpful to homeless persons and families as well as the shelter community. It is also undertaking city-wide coordinative and advocacy functions.

All of the activity on the part of State government was reinforced by legislative passage, in the fall of 1983, of an omnibus bill which combined a number of proposals advanced by the Governor, the Massachusetts Coalition for the Homeless and the leadership of the House and Senate. These include expansion of emergency assistance programs for families, development of a public-private partnership program with shelters by the Department of Social Services, and a technical assistance program for shelters by the Executive Office of Communities and Development.

On the Federal level, first steps were also taken toward meeting the needs of homeless persons and families. As part of PL 98-8, the Job Stimulus Bill, $100 million of federal funds were allocated for emergency food and shelter programs. A National Board allocated half of this money to areas of high unemployment. The other half was distributed to each state through the Community Services Block Grant formula. In the Greater Boston area these monies were allocated by two groups: a Planning Committee established by the Governor's Advisory Committee on Homelessness and a Special Advisory Group established by the United Way of Massachusetts Bay. Staff of these two groups worked together closely to ensure that the money was used as efficiently as possible. Advocates for the homeless hope that Federal support for emergency shelter and food programs will continue and that in future years the Federal funds will continue to be allocated by community groups, knowledgeable about local conditions.

If future funding is provided, it is hoped that regulations will be issued which will be less restrictive than those promulgated in 1983. These regulations prevented many shelters and meals programs from using the available funds in the most efficient way.

IV. THE EXISTING EMERGENCY ACCOMMODATION SYSTEM

A. Definition

Greater Boston area shelters are united by their common goal which is to provide the necessities for survival to homeless men, women and children. Beyond this unifying factor, however, they represent a very diverse group of agencies. To give some structure to this diversity, we have divided these programs into two categories: those who provide shelter on a night-to-night basis and those which provide more stable housing over a period of weeks or months. The first group, which is discussed in this section, is termed the Emergency Accommodation System. The second group is termed the Transitional Shelter System.

The term "system" is somewhat misleading, since neither group is formally organized. Nevertheless, there are strong and effective informal linkages within and between these systems. Staff and directors of each shelter are likely to have friends working in a number of other programs and will often share information regarding the needs of specific persons who move from one shelter to another.

The group of shelters within the emergency accommodation system share some key characteristics:

-- They provide each guest with basic survival services on an overnight basis only. During the day guests are required to leave the facility. Many of these shelters are staffed primarily by volunteers with a minimal number of paid staff. Closing the shelter for part of the day reduces the need to recruit volunteers to cover those hours and gives paid staff time to perform necessary administrative tasks. It also greatly simplifies the task of cleaning the building, changing sheets, and doing other such tasks.

-- With two exceptions (Shelter, Inc., and Rosie's Place) the emergency accommodation shelters will not accept children.

-- Most emergency accommodation shelters assign beds randomly so that guests sleep in a different location within the shelter each night.

B. A Roster of Emergency Accommodation Shelters

The first five shelters in this list are located in the South End or, in the case of Long Island Hospital shelter, have their intake point in the South End. Other shelters are located in Jamaica Plain, downtown Boston and in the Central Square area of Cambridge. As of May, 1983, no emergency accommodation shelters were operating in any of the other five cities investigated, although one had operated in Brockton during the winter of 1983.

-- Pine Street Inn, located on the corner of Bristol Street and Harrison Avenue, contains 300 beds for men and 50 beds for women. (In the winter months up to 250 additional men sleep on the floors, in the lobbies and in the stairwells.) There is no limit on the number of consecutive days a person may return to Pine Street. Evening and morning meals are served.

-- Harborlights is located at 407 Shawmut Avenue. It contains 30 beds for men and seven for women. Fifteen of the beds for men and one of the beds for women are considered "intermediate" while the remainder are "transient." Breakfast and dinner are served to persons staying at the shelter. A full lunch program is available for persons walking in off the street at the Noon hour. Sandwiches are also served during the afternoon.

-- Rosie's Place is located at 1667 Washington Street. At the time of our survey it contained ten beds but has since expanded to fifteen. Women may stay six consecutive days and then must sleep elsewhere for two weeks. Women with children occasionally stay at Rosie's place if beds are available. An evening meal is served every night of the week. On Sunday a dinner is served starting at 1:00 p.m. During the past winter Rosie's began serving lunch for street women Monday through Friday.

-- Sancta Maria is located at 11 Waltham Street. It contains nine beds for homeless women. Women may sleep at Sancta Maria for three consecutive nights, then cannot come back for a month. No regular evening meal is served although a snack is usually available. The women are given breakfast before they leave.

-- The Shelter at Long Island Hospital is located on one of the Boston Harbor Islands. It is considered one of the South End shelters because persons wishing a bed must go to Boston City Hospital to undergo intake. There is no limit on the number of days a guest may return. It provides 100 beds for homeless men and women.

-- Shattuck Hospital Shelter is located on the Shattuck Hospital grounds on Morton Street in Jamaica Plain. Since opening in January, 1983, its role has been to serve as an overflow shelter for all other Boston shelters. Until the end of April, it accepted families but now serves only homeless men and women. It provided 115 beds when it first opened, although at times in the winter it served as many as 140 guests a night. The location of the shelter on the hospital grounds has been changed and it now provides 50 beds. There is no limit on the number of consecutive days a person may return to the shelter. Evening meals as well as breakfasts are served.

-- Commonlife is located at 203 Tremont Street in Boston. It serves young men and women over 18 and under 21. Because they are legally adults, they cannot be served by shelters which serve runaways and other youth. It has 16 beds. There is no limit on the number of days people can stay. Only breakfast is served. (This shelter closed temporarily in the fall, 1983.)

-- Shelter, Inc. is located in Central Square in Cambridge. Its primary role is to serve homeless men and women who are recommended through social agencies in Cambridge and Somerville. When room is available, referrals from agencies in Boston and other cities are accepted. It provides 15 beds for single men and women as well as five beds for families. Single men and women are allowed to stay for three nights consecutively and then must stay away for two weeks. (There are exceptions granted to this rule.) Families may stay six to eight weeks. An evening meal as well as breakfast is served.

-- CASPAR Emergency Service Center is located at 240 Albany Street, Cambridge. It serves only homeless alcoholics from Cambridge and Somerville. It has 35 beds. There is no limit on the number of consecutive days people can stay. However, CASPAR uses this facility as a point of entry into its other programs for alcoholics so that from the first day attempts are made to move guests on to other programs. An evening meal, breakfast and lunch are served.

The total number of beds represented by these nine facilities is 687. Of these, 76 are "reserved" for homeless women at Pine Street, Rosie's, Harborlights and Sancta Maria. Women also stay at the remaining shelters but their numbers vary from night to night.

Pine Street Inn and Harborlights "reserve" a total of 330 beds for men while in the other shelters beds are provided to men or women as needed.

In all cases, these figures represent the listed capacities of these emergency accommodation shelters. It has already been noted that Pine Street Inn allows many more homeless men to sleep on the floors and stairwells during the winter months. (Occasionally, homeless women are provided for in this way, but only if Pine Street staff cannot find accommodations for them elsewhere.) At various times during the winter of 1982-83, staff at Long Island, Shattuck, the Emergency Service Center, and Rosie's reported that men and women were sleeping on the floors or in chairs because no bed space was left.

CHART ONE

Summary of Emergency Accommodation Bed Supply

(May, 1983)

Name of Shelter	# of beds	Comments
Pine Street Inn	350	50 for women, 300 for men
Harborlights	37	7 for women, 30 for men
Rosie's Place	10	10 for women
Sancta Maria	9	9 for women
Long Island Hospital	100	Varies each night
Shattuck	115	Varies each night
Commonlife	16	Varies-usually 2-3 women
Shelter, Inc.	15	Varies each night
CASPAR Emergency Services	35	Varies-usually 2-3 women
TOTAL	687	

C. Other Sources of Overnight Shelter

In the course of research for this report, we found that Boston's detoxification centers are perceived as part of the shelter network by many homeless persons. While rules governing intake into the detoxification programs require individuals to be sober, they allow a certain number of persons under the influence of alcohol to sleep overnight without going through intake. When they are sober, an attempt is made to enroll them in the detoxification program. In practice, homeless persons have told us, alcoholics among the street population now see detoxification programs as suitable places to seek overnight shelter.

Other alterntive sources of overnight shelter, both for families and for homeless individuals, are found in the various rent voucher programs operated by a number of churches and social agencies. These social agencies rent low-cost hotel and motel rooms for homeless persons, usually for a very limited period of time. A staff person of the agency is responsible for working with the individual or family to facilitate their resettlement. The following programs provide a significant amount of such short-term shelter:

-- The Disaster Assistance Unit of the Massachusetts Bay Chapter of the American Red Cross will pay for temporary lodging for three to four days in hotel rooms or YMCA's and will provide vouchers to pay for meals. This service is limited to those who lose their homes or apartments through fires or other natural disasters. Red Cross staff will also provide vouchers for clothing and some household furnishings if needed. When a new apartment is found the Red Cross will assist with the first month's rent.

-- The Travelers Aid Society will sometimes pay for lodging and meals for families or individuals who are stranded in Boston without funds. This assistance is provided as part of a more general casework plan for the family or individual. The length of time aid will be provided depends on the case. As part of the Relocatee Program, Travelers Aid will occasionally rent a room or apartment for someone who has come to Boston and found a full-time job but who does not have money for rent. This money is considered a loan to be repaid when the first paycheck is issued.

-- Social Action Ministries of Greater Boston will rent hotel or motel rooms for homeless families referred to them by churches or social agencies. A member of the staff of the referring organization is responsible for working with the family in order to help them find other housing. Funds to support this program are contributed by various churches.

-- The Salvation Army in Lynn, uses its own funds and monies made available through the Emergency Fund of United Way Information and Referral to rent rooms in rooming houses. Since very few rooming houses will accept families, this is primarily a service for individuals. The director of this program indicated that most clients were men who had been living in local rooming houses and who had histories of emotional illness. Because Lynn has some 50 rooming houses, it is possible to accommodate most individuals through this program.

-- A local priest in Quincy has, for the past two years, been renting motel rooms for families and individuals. Funds contributed by his own parishioners are used in this work.

-- The North Shore Community Action Program in Salem/Peabody provides emergency accommodations for families by renting motel rooms. This agency has only a small amount of money of its own for this purpose. Contributions to this fund are made by local churches, charitable agencies, and individuals. Staff works with families to seek more permanent housing.

-- The United Way of Massachusetts Bay and the Governor's Office of Human Resources provided through Federal funds distributed in 1983 another resource for agencies renting motel rooms or hotel rooms for families and individuals. In some instances agencies who already were operating sheltering programs were able to use these funds as a way of sheltering some persons who would otherwise have been turned away.

-- The Massachusetts Department of Public Welfare has developed two separate systems for the provision of vouchers for shelter. At the time of our study (winter and spring of 1983), homeless men and women could obtain such vouchers only if they applied at the Homeless Persons Unit located on Hawkins Street. In February, 1983, the Department allowed their offices in all parts of the Commonwealth to issue such vouchers. Individuals are expected to apply for General Relief as soon as they obtain a room.

-- The Emergency Assistance Program is intended to help AFDC recipients and other families who meet eligibility standards and who are faced with some type of crisis. Vouchers for temporary shelter are available for eligible families.

-- Other: In addition to these "official" efforts, there are a number of "unofficial" places where homeless people are allowed to stay in a kind of semi-protected environment. Among these are hospital waiting rooms, restaurants, cafeterias and police stations. Kindly individuals in such settings tolerate the presence of homeless people if they are peaceable and are able to maintain socially acceptable behavior. In return, they are protected from dangers of life on the street and in some instances fed as well.

There are many other less protected public spaces where homeless people sleep. Included among these are the Boston subways, abandoned buildings, public garages, the vestibules of churches and businesses and transportation terminals.

D. Specialized Services Available in Emergency Accommodation Shelters

"We treat people with respect. When they come through that door we welcome them and we treat them the way people should be treated. We make them feel good .. and everywhere else they go people make them feel bad."

This quotation from the former Director of a shelter for homeless women summarizes the "basic service" the shelters provide for the street people who come to their doors. For the most part, shelters are founded by women and men who are deeply concerned about homeless people and who wish to provide companionship in addition to a meal and a safe place to sleep. While there are individual variations between shelters, most staff and volunteers are quite conscious of the fact that every homeless person is in great need of gentle, respectful and courteous treatment. The universal practice among shelter staff of referring to homeless persons as "guests" is a continual reminder that they are "hosts" and that their behavior should be tailored to that role.

The style of "service delivery" in the context of a shelter program is different from the style familiar in a more conventional human service agency. There are no appointment schedules, very few private offices and very little of the "intake process" which is so familiar in the orthodox service agency. Experienced staff feel that these formal procedures of agency life would frighten off homeless men and women who are already suspicious and wary. Personal trust must first be won. Only then can a staff person provide any kind of usable help.

Because the service delivery style is so informal, it sometimes appears to outside observers that there is no service program at all. Nevertheless, as guests, staff and volunteers interact, certain recognizable social services are provided.

-- Case Advocacy -- Virtually every shelter within the emergency accommodation system has the ability to provide some type of case advocacy for its guests. In some instances, paid staff are the full time advocates while in others two or more volunteers share the role of "advocate." In either case, advocates spend their time attempting to obtain for homeless people financial assistance, medical care, mental health treatment, and a wide variety of other services.

-- Case Management -- In most shelters "case advocates" are also "case managers" in that they take responsibility for obtaining needed services of many types for the same guest. To provide case management effectively, the worker must stay with the shelter program for a period of time so that she/he can gain the necessary knowledge of service systems and the connections inside each system to facilitate access to service. For this reason, it is usually paid staff rather than volunteers who play this role.

-- Information and Referral -- Not every guest needs or wants an advocate who will aggressively pursue services for her or him. However, in the informal interaction within the shelter staff members may "happen to mention" how certain services can be obtained or where a guest might go to seek help. At times the information offered is quite personalized. For example, a staff member may tell a guest to ask for a specific physician at a medical clinic because that particular doctor is known to work well with street people.

-- Housing Assistance -- Virtually every shelter director we interviewed indicated that staff and volunteers attempt to help some guests to find affordable permanent housing. Staff in some shelters have developed good personal relationships with a few local landlords who will accept guests upon staff recommendation.

-- Special Access to Long-Term Shelter -- CASPAR Emergency Service Center, Rosie's and the Pine Street Inn all have developed programs which provide guests with access to long-term shelter.

    -- The CASPAR Emergency Services Center was conceptualized as a triage point for all of CASPAR services. From the first day, staff make a major effort to get each guest off the street. One way of doing this is to place the guest in one of the halfway houses operated by CASPAR. Staff evaluates the possibility that a guest will "fit in with" people already living in a particular facility. Because CASPAR has complete control over who goes into each halfway house, they can provide a bed when it appears an alcoholic is ready to use a halfway house experience constructively.

    -- The Parker Street Shelter at Lindemann is a long-term shelter program for persons suffering from chronic mental illness. Intake into this program is restricted to persons selected by a committee of staff from Pine Street, Rosie's Place, and the Parker Street Shelter. Guests are referred to the Parker Street program as beds become available. Staff select individuals who are willing to enter the program and seem likely to profit from it.

-- Bridgewater State Hospital operates what is, in effect, a long-term shelter for male alcoholics. Any guest at Pine Street Inn can sign up for a voluntary stay at this facility if he wishes. Pine Street has organized a transportation service which sends a van down to Bridgewater twice each day. At Bridgewater, men who wish to leave are picked up and returned to Pine Street. While Bridgewater admits men from other locations much of its population comes to it through Pine Street Inn. Pine Street Inn staff state that Bridgewater is seen by many homeless men as providing a highly acceptable alternative to being "on the street," especially in the winter.

-- Access to Health Care -- Because so many homeless men and women have major medical problems, the staff of these shelters are concerned with access to emergency medical care. Those shelters located in the South End commonly call upon Boston City Hospital and Massachusetts General Hospital for emergency services. Shelters in Cambridge use the emergency room of Cambridge City Hospital.

Staff and volunteers at all these shelters seek to obtain outpatient care for homeless individuals, usually from the same medical facilities used for emergency treatment. Because large numbers of homeless people have no medical insurance, this type of advocacy is considered especially difficult.

Some shelters have developed a program of outpatient care within the shelter itself. Most notable is the Pine Street Inn Medical Clinic which provides free care every evening to all who request it. Paid staff are supplemented by volunteer physicians and nurses. The Medical Van operated by Bridge Over Troubled Waters, which is also staffed by volunteer professionals, visits Shelter, Inc. and Commonlife. The van is equipped to provide diagnosis and simple treatment.

Long Island Hospital Shelter, which is operated by the City of Boston Department of Health and Hospitals, makes medical care available at the shelter itself. In addition, volunteers from the shelter accompany guests to outpatient clinics at City Hospital and obtain medication for them.

This listing is not intended to be exhaustive but gives an idea of the type of services available at these shelters. However, it should be pointed out that the number of volunteers and staff available to deliver these services is quite small. Furthermore, the work can be immensely time-consuming because it can take many hours to straighten out just one welfare problem or to persuade a landlord to rent a room to one homeless person.

In general, the shelter directors who were interviewed indicated that, despite their best efforts, many of their guests received only the minimal survival services during their stay at a shelter. Many homeless men and women cope with the outside world by pulling away from attempts to help them. These barriers can be broken down, in time, by patient friendliness and unobtrusive offers to help. This painstaking work does not suit every potential volunteer or staff member. Virtually all shelter directors are continually recruiting volunteers who have personalities which will allow them to work with the guests.

There is a shortage of money to pay staff to provide these services. Here it should only be noted that many shelters feel a need for more paid staff to meet all the service needs of their guests.

E. Day Programs: Supplement to the Emergency Accommodation System

The network of shelters which we have called the emergency accommodation system requires each guest to leave the shelter after a morning meal. This particular operating principle has its historical roots in the 19th century missions. In these precursors of today's shelters, the assumption was always that it was healthier for men to be given an inducement to go out and find work. To provide a 24-hour-a-day "Home" for men who were not elderly or clearly ill was never a goal.

For some individuals, shelters serve the traditional function of a base from which to look for work. The majority, however, have either given up looking for work or are simply too disabled -- usually because of chronic alcoholism or mental illness -- to be hired.

It is our impression, gained through interviews with shelter directors, that because the emergency accommodation shelters were closed during the day there was a great need for day programs to meet the needs of Boston's homeless.

Day programs vary in the amount of structured services they offer. Some are simple drop-in centers where homeless persons may sit down, socialize with one another and store belongings in lockers. Others are tightly organized programs where many specific services are offered.

Examples of existing programs include:

-- Project Place in the South End currently allows homeless persons to use its first floor room as a kind of informal drop-in center. Staff tries to provide assistance if it is requested but primarily seeks to provide a congenial atmosphere where people can get off the street and relax.

-- Both the Pine Street Inn and Long Island Hospital Shelter have developed "guest worker" programs which are, in effect, day programs. In these programs, guests are recruited to work in the maintenance crew of the shelter during the daytime hours. A small wage is paid the guest and beds are reserved for them each night. However, neither of these programs can absorb a large number of guests. Some elderly and disabled guests are allowed to stay at Pine Street during the day.

-- On two days each week, a day center for homeless people now operates at the Salvation Army Corps Center in Central Square Cambridge. This center provides lockers, laundry facilities and meals on the days it is open.

-- Currently, there are a number of structured day programs specifically designed to meet the needs of mentally ill persons. While many of those who frequent programs such as Center House in Boston and Friendship House in Lynn are not literally homeless, a few are. These programs have developed techniques of working with mentally ill persons which could be used in other settings as well.

In our interviews, shelter directors mentioned two populations in particular need of the kind of physical and social protection a day program would provide. The first group was composed of elderly men, usually alcoholic, who frequent the South End shelters. These men are fearful of the younger homeless men who verbally and physically abuse them. One director said: "They need a place they can go off by themselves to escape the young men."

The other group is made up of young pregnant women who are living in emergency accommodation shelters. The director of one South End shelter stated that a day program for them, if operated in an unpressured way without insisting on steady participation each day, could provide these young women with a respite from the street which they need and cannot presently obtain.

Interviews with service providers in Lynn and in Salem indicate that in those communities there is an immediate need for some type of day drop-in center which will be available to men and women, some of them actually homeless, others in a state of quasi-homelessness.

F. Meals Programs: Supplement to the Emergency Accommodation System

> "I can get all kinds of 'human services' for these guys. This city is full of agencies who want to 'help'. But to get a plate of ham sandwiches so I can feed them ... I have to rely on some little restaurant owner for that."

The shelter director quoted above feeds 50 or 60 hungry men and women a day primarily with donated food. Finding food is a continual preoccupation for street people. Many of them have become very adept at scrounging food from sympathetic restaurant workers, the proprietors of fast food outlets and store owners.

Shelters all have meals programs which to a greater or lesser extent meet the nutritional needs of their guests. Some, such as Rosie's place, customarily serve dinner to many homeless persons whom they cannot accommodate for the night because of the lack of room.

In addition to these sources of food, however, a network of "meals programs" has developed in Boston and Cambridge which supplies lunches and dinners to poor people who are homeless as well as to many who are not. Directors of emergency accommodation shelters were unanimous in their feeling that many more persons would be homeless if it were not for this network of programs. Older men or women living on Social Security benefits or younger ones living on General Relief are sometimes just able to eke out enough money to pay their rent by taking most or all of their lunches and dinners at these meal programs.

Most of these programs have been initiated by clergy or laypeople associated with churches or church-sponsored organizations. Some provide a lunch or dinner on one day only while others serve a meal almost every day of the week.

Meals programs have also been developed in cities outside of Boston and Cambridge as church groups and other community workers began to see the need for such a service. For example, My Brother's Table in Lynn serves approximately 200 meals a day. Only a small number of these guests are homeless but many reportedly would be if these free meals were not available. In Salem, Brockton and Quincy similar meals programs are operating at least one day a week.

Both shelter directors and operators of meals programs continually solicit other groups, especially church groups, for food. The Pine Street Inn and some other shelters have organized a program through which churches volunteer to serve one dinner on a designated day each month, providing the food, transporting it to the shelter, cooking it, serving it, and cleaning up after the meal is served.

Shelter and meals programs make extensive use of the Boston Food Bank, a non-profit agency which obtains donations of food, primarily from manufacturers and large food store chains, and makes it available for ten cents a pound to qualifying agencies. This effort and others are partially funded by Project Bread, a fundraising program supported by proceeds of the Walk for Hunger and other donations. The Hunger Hotline, established by Project Bread in 1982, collects and disseminates information about the problem of hunger in the Greater Boston area and organizes community efforts to meet these needs.

G. A Final Comment on the Emergency Accommodation System

This network of shelters, which we have called the emergency accommodation system, cannot reasonably be expected to meet all the social and psychological needs of its guests. While the survival services may be provided to all, only a portion receive adequate attention to their emotional, physical or legal problems. Financial and staffing problems account for part of this shortfall. The internal rules and regulations of the emergency accommodation shelters which require a daily turnover of guests makes it extremely difficult to establish the kind of personal relationship and trust required as a basis for providing concrete help. Yet, in a very real sense, these programs are the only "safety net" available in the Greater Boston area for the totally destitute. Ignored, until recently, by media, public and other agencies the survival services and the people who provide them continue to save lives and to offer companionship to persons who would otherwise be totally alone.

The metaphor of "dropping through the cracks" has become a cliche. But sheltering organizations, themselves, seem to have shared the fate of their guests. Until the recent upsurge of interest inspired by Governor Dukakis' intiative in this field, there was virtually no contact between the leadership of the shelter programs (board and staff) and the leadership of traditional human service programs. This was because their guests were seen as persons who could not or would not make use of the services these agencies had to offer.

V. THE TRANSITIONAL SHELTER SYSTEM

Among many shelter directors and advocates, the term "transitional housing" is used to denote facilities in which an individual or a family may stay until they find permanent housing. This period of time can be anywhere from a few weeks to eight or nine months. However, there has been no agreed upon definition of what "transitional housing" is or how it differs from "shelter" as the term is commonly used.[7/]

In this report we use the term "transitional shelter" to embrace a number of different programs including a few which define themselves as "transitional housing" in the sense given above. All of these programs share a variety of characteristics which set them apart from the aforementioned emergency accommodation network. All provide the basic survival services to homeless persons or families and are, therefore, included in this study as sheltering programs. Their central characteristics are these:

-- They are organized in such a way as to provide guests with an orderly, predictable and stable environment. Each guest is assigned his or her own bed which is retained for the length of their stay. Guests are encouraged to leave belongings in the shelter when they go out. Guests are not required to leave the shelter after breakfast each day, although in practice many are encouraged to do so.

-- With one exception (Parker Street) all of these shelters accept women and children. Some will also accept adult men if accompanied by a woman or by a woman and children. A few shelters also accept homeless women unaccompanied by children.

-- In most of these shelters a plan is made with the guest which is tailored to individual or family needs and capacities. One of the central goals of this plan is to help him/her obtain permanent housing.

-- In most of these shelters guests are expected to conform to rules of behavior which are established and enforced by meetings in which both staff and guests participate.

7/ Ms. Leslie McCulloch, an intern working at United Community Planning Corporation, prepared a survey paper, Meeting the Needs of Displaced Persons: Models of Transitional Housing, 1983, which clarified many of the definitional issues relating to this term.

The following roster of transitional housing shelters will begin by listing those which primarily or exclusively serve battered women and their children. This group of shelters is closely knit together by their participation in the Coalition of Battered Women's Service Groups, a statewide organization. The remaining shelters, which primarily serve families but have a more varied clientele, have more informal linkages based upon the personal contacts of directors and staff of the various programs. There are also many informal contacts between these shelters and those of the Emergency Accommodation System.

A. A Roster of the Transitional Shelter System

The first eight shelters on this list serve women and children who have fled domestic violence. For reasons of security, these shelters will not provide their exact address. The remaining six shelters serve only families except for the Parker Street program which accepts only mentally ill street people.

-- Casa Myrna Vasquez and Mary Lawson Forman House are two shelters with 20 beds each. One is located in the South End while the other is located in Dorchester. These shelters, which are administered by the same board, serve women and children from all ethnic and cultural backgrounds who have been physically or psychologically abused. No males older than 12 are accepted. The maximum length of stay is six weeks but exceptions are granted depending on the guests' situation. Guests prepare their own meals. Child care is available.

-- Elizabeth Stone House is located in Jamaica Plain. This shelter originally served only women in emotional distress who have a history of mental illness and who could turn to neither family nor friends. It still maintains 15 beds for such women and their children but now operates a six-bed program for battered women as well. Women with and without children are accepted. Women may stay five months if they enter the Therapeutic Counseling program but only eight weeks in the Battered Women's program. Women buy their own food and prepare it themselves in a community kitchen.

-- DOVE (Domestic Violence Ended) is an 18-bed shelter located in Quincy. It serves women and children fleeing abusive situations. The length of stay is set at two weeks but can be extended from week to week depending on circumstances. Women provide their own meals.

-- Transition House is an 18-bed shelter located in Cambridge. It serves battered women and their children, placing as much emphasis on the needs of the children as upon those of the mothers. No males older than age 13 are accepted. Maximum length of stay is set at eight weeks. Transition House is a collective household in which guests buy and cook the food for meals.

-- Renewal House is a 12-bed shelter located in Roxbury. It serves low-income women, primarily those with children, who are in some type of crisis. The three largest categories are battered women, women who have been evicted, and adolescent mothers unable to settle or maintain a home. No males over the age of 12 are accepted. The maximum length of stay is eight weeks but extensions may be granted. Each family purchases its own food and cooks its own meals.

-- The Waltham Battered Women's Support Committee operates a ten-bed shelter in Waltham. It serves physically battered women and their children. No males over the age of 12 are accepted. The maximum length of stay for women with children is six weeks while for women without children it is four weeks. Extensions are rarely granted. Guests are responsible for their own meals, prepared in a common kitchen.

-- Respond is a six-bed shelter for battered women and their children in Somerville. The usual maximum length of stay is four to six weeks. Women are responsible for preparing their own meals.

-- Womensplace is a shelter for battered women and their children. It is located in Brockton and is operated as part of the Health Care Program of Southeastern Massachusetts. Length of stay is set at six weeks. No males over the age of 13 are accepted. Guests provide and prepare their own food.

-- Parker Street is a 50-bed shelter located at the Lindemann Mental Health Center in Boston. It accepts only homeless men and women with emotional problems referred from Pine Street Inn and Rosie's Place. No children are accepted. The length of stay is flexible. In most cases guests are not moved out until they are ready for permanent housing. Breakfast and dinner are available to guests at the Lindemann cafeteria. Lunch is provided at the Metro Day Program which guests attend each day. Guests help to prepare lunches.

-- The Temporary Home for Women and Children is a 45-bed shelter located at 41 New Chardon Street in the Government Center area. It serves homeless mothers and their children. No males over the age of eleven and a half are accepted. The maximum length of stay is set at 45 days, but exceptions are made in some cases. Three meals a day are served. Counseling is provided to guests on an ongoing basis.

-- The Boston Family Shelter of Shelter, Inc., is a 35-bed facility located at 656 Massachusetts Avenue. It serves homeless families. Adult males are accepted. Guests prepare their own meals. Length of stay is negotiated with each family.

-- Sojourner House is a 20 bed shelter for families located at 85 Regent Street in Roxbury. Homeless families, including male adults, are accepted. This program considers itself "transitional housing." Therefore, no family is asked to leave until acceptable permanent housing is found for them. Guests prepare their own meals.

-- Project Hope, located on Magnolia Street in Dorchester served only female adolescents and their young children at the time of our survey. It had six rooms, each of which could accommodate two people. With the help of a grant from the State Department of Public Welfare it has expanded to a twenty-bed family shelter with no age limits. Length of stay is set a sixty days.

-- The Roxbury Corps Center of the Salvation Army operates a shelter at 23 Vernon Street in Roxbury near Dudley Square. It has four rooms with one family in each room. The number of beds varies from 8-12 at any one time. The length of stay is set at seven days but in practice extensions are frequently granted. Guests prepare their own meals.

The total number of beds represented by these 14 facilities is 303. However, most of these shelters have been developed to serve one particular population. The chart below is an attempt to summarize these subgroupings.

CHART TWO

Summary of Transitional Shelter Bed Supply

(May, 1983)

Name of Shelter	Number of Beds	Population Served
Casa Myrna/Forman	40	Battered women and their children
Elizabeth Stone	21	Battered women and their children (6 beds). Mentally ill women and their children (15 beds)
DOVE	18	Battered women and their children
Transition House	18	Battered women and their children
Waltham Battered Women's Shelter	10	Battered women and their children
Respond	6	Battered women and their children
Womensplace	16	Battered women and their children
Parker Street	50	Mentally ill homeless adults
Temporary Home	45	Homeless families
Boston Family Shelter	35	Homeless families
Sojourner House	20	Homeless families
Project Hope	12	Homeless adolescent mothers
Roxbury Salvation Army	12	Homeless families
TOTAL	303	

These figures indicate the maximum bed capacity of each of these shelters. The number of families which can be accepted at any one time is, of course, dependent on how large the family groups are. During our research period (November 1982-May 1983), shelter directors told anecdotes of families with seven, eight or nine children seeking shelter. However, they were in agreement that these families were exceptionally large and that the usual family seeking shelter was composed of a mother with one or two children.

In some shelters the number of families who may be accepted at any one given time is limited by the physical arrangement of the facility. Several directors indicated that each family was assigned its own room and that beds were moved from room to room to accommodate larger families. When they did not have room for a family they would usually indicate that they did not have a "room" rather than not having "beds."

The following chart translates the number of beds available in the transitional shelter system to an estimate of the number of families which may be accommodated in each. These estimates are expressed in ranges when shelters indicated they had flexibility.

CHART THREE

Estimated Number of Families Which Can Be Housed

In Transitional Shelters

(May, 1983)

Name of Shelter	General Family Shelter	Battered Women Shelter	Mentally Ill Homeless Adults	Mentally Ill Women & their Children	Adolescent Mothers
Casa Myrna/Forman		12-16			
Elizabeth Stone		2-3		3-6	
DOVE		4-7			
Transition		4-7			
Renewal		5			
Waltham		2-4			
Parker Street			N/A		
Temporary Home	13-15				
Boston Family Shelter	10				
Sojourner	4-5				
Project Hope					6
Roxbury Salvation Army	4				
TOTALS	31-34	29-42		3-6	6

The estimated capacity of the entire system ranges from a low of 69 families to a high of 88. The actual number of families sheltered at any one time is probably around 80.

B. Other Sources of Transitional Housing

In a previous section we noted that during the 19th Century the Commonwealth created a State Almshouse in Tewksbury and a State Workhouse in Bridgewater to house the "unsettled poor" of that time. While the legal status of the clientele has changed, as well as the formal names, these institutions still provide long-term shelter to many homeless men.

The Massachusetts Correctional Institution at Bridgewater is the institutional descendent of the original State Workhouse. Originally a penal institution primarily intended to confine tramps and vagabonds, it slowly evolved into a complex of institutions where many different types of offenders were imprisoned. This evolution resulted in the creation of a special facility where chronic drunkenness offenders from all over the state were confined. This practice ceased with the decriminalization of public drunkeness as an offense. However, MCI Bridgewater continued to provide beds, meals and supportive services to men who voluntarily entered the facility. On the night of our census of Boston/Cambridge shelters (February 25, 1983), 448 men slept at the Bridgewater Addiction Center. Staff indicated that all but a few of these were homeless men from Boston or from some other part of the State. Many of these men voluntarily leave Bridgewater in the Spring and went back on the street in Boston or in some other community.

Tewksbury State Hospital, administered by the Massachusetts Department of Public Health, is the descendent of the State Almshouse. From its inception it was defined as a charitable rather than a penal institution. It evolved in the direction of providing medical care for indigent persons, including alcoholics. Demone and Blacker, quoting a study done in 1948, indicated that of 5,000 male admissions two-thirds were chronic alcoholics.[8/]

Tewksbury State Hospital has since developed a number of other special programs, but the provision of care and treatment to alcoholics remains part of its mission. On February 25, 1983, 190 homeless men were staying at Tewksbury. Staff indicated that most were alcoholics from the cities of Lowell, Lawrence and Haverhill with a scattering from other communities. Customarily, they stay 90-100 days leaving when the weather becomes warmer.

8/ Demone and Blacker, op. cit., p.32.

Neither of these institutions overtly presents itself to the community as a "shelter for homeless men." In both cases the service provided to homeless men is only one aspect of a varied program of services. Yet, shelter directors in Boston consider the Bridgewater Addiction Center to be a valuable resource, sheltering as it does alcoholic men who probably would not easily survive the rigors of life on the streets of Boston in winter. Tewksbury's value is primarily to the charitable agencies of the Merrimack Valley. Both make an important, though largely unrecognized, contribution to the total supply of shelter available to homeless men.

In the course of our research, it became clear that there were other facilities which similarly do not call themselves "shelters" but do in fact provide long-term shelter to homeless men and women. However, such shelter is provided unintentionally. What has happened, in each case, is that homeless men and women have involuntarily or voluntarily been placed in a type of residential program which is therapeutic in nature. These programs typically assume that, after a certain period of treatment, the individual will return to his or her own home. Yet when the period of treatment is completed, these individuals have no home to which they can go. Some programs simply discharge these individuals to the street. Others, operating within other legal frameworks or traditions of service, continue to shelter them while seeking to locate a viable housing arrangement for them.

-- Inpatient units at mental health centers and state mental hospitals admit many homeless people. Interviews with staff at these facilities both in Boston and in other cities indicate that quite often such individuals would be ready to leave the program but could not because proper housing arrangements could not be made.

-- Medical hospitals which admit homeless persons differ in their policies regarding discharge. In Boston some simply advise patients to return to the shelter circuit or make a referral to a particular shelter director. Others will evaluate cases more closely and will seek alternative placements in nursing homes or rest homes. Nevertheless, some individuals badly in need of nursing home care are difficult to place. In such instances, hospitals may find themselves providing a type of long-term shelter service keeping the individual as an in-patient until such a placement can be made.

-- County jails receive from the courts homeless men arrested on a variety of charges. Interviews with shelter directors indicate that judges will sometimes accept "Guilty" pleas from homeless men in order to "place" them in county jails during the winter months. Unfortunately the parole officers working in county institutions have neither the time nor the resources to resettle homeless men successfully in their community of origin. With ties to friends and family thoroughly broken, these men often drift to Boston to wherever "emergency accommodation" shelters exist.

One type of specialized sheltering program which has been developed for battered women and their families may be considered still another source of transitional shelter. These are networks of "safe houses" where women and their children may stay for short or long periods of time. Sheltering agencies recruit families who make their homes available to women. Casa Myrna and Transition House also administer a network of "safe houses" for women who do not wish to stay at the shelter. In addition, there are three programs in the Greater Boston area, HAWC in Salem, Harbor Me in East Boston, and the YWCA program in Natick which have organized safe house networks.

C. Special Services Available in Transitional Shelters

Directors and staff of emergency accommodation shelters provide service to their guests in a very low key and informal fashion. Transitional shelters tend to provide services in a more structured way. However, it should be noted that even the programs which seem highly formal when compared with emergency accommodation programs, appear informal when compared with more traditional halfway houses or group homes.

While there are many similarities between the subgroup of shelters for battered women and the subgroup of general family shelters, there are some differences in philosophical outlook which affect the styles of service delivery. For the most part, both groups of shelters serve persons with very low incomes. The general family shelters tend to define the main problem of their guests as being "trapped in a state of homelessness" because they are unable to afford the rents in the Greater Boston area. The staff and directors of battered women's shelters agree that their guests are trapped in the same way but that, as victims of domestic violence, they have also been victimized by an abusive male and by a society which encourages among women attitudes of weakness and dependence.

While these differences in outlook result in different emphases in the ways services are delivered, the two subgroups have developed a number of core services which are remarkably similar. The following description will make distinctions between the subgroups when they appear to be useful.

-- Emotional Support/Training for Independence -- Within the transitional shelters very intense feelings of rapport and companionship grow up among the guests and between the guests and staff. Some shelters organize guests into "support groups" where practical problems, as well as emotional issues, may be discussed. However, even in those shelters where no formal support groups are formed, the interactions between the families tend to move in the direction of mutual support and trusting relationships. Virtually all of these shelters encourage families to share in the planning, preparation and serving of meals. This has the effect of "training" new families in the informal customs of the shelter and offers newcomers a chance to become part of the group at their own pace.

  While this support is being given, shelter guests also receive another message both from staff and their fellow guests: They are expected to begin to "work on their problems" as soon as possible. Great emphasis is placed on the need to "do things for yourself" during this socialization process. Shelters for battered women particularly emphasize the necessity of each woman accepting that "she must stand on her own feet" in order to be free of the man who has abused her. Directors of battered women's shelters stressed that it was far from easy for many women to accept this reality and that the themes of self-worth and independence must continually be stressed.

  There are two specific techniques used by virtually all transitional shelters which urge guests on toward independence. The first is the "house meeting," a weekly event at which staff and guests meet to discuss administrative problems, rule infractions and progress toward goals. Through participation at these meetings, guests learn both that they will be held responsible if they break certain house rules and that they must work toward establishing an independent household.

  The other technique is the early development, by each guest, of a financial plan. In most shelters, each adult guest is required to open a bank account in order to begin to accumulate money toward the deposit and first month's rent on an apartment. Unless special circumstances exist, guests are required to deposit some portion of each benefit check, salary or other money she may obtain in this account, which is monitored by a responsible staff person. This device makes the idea of living independently seem more possible to the guest.

-- Housing Assistance -- Every transitional shelter has some type of housing assistance program. Only rarely, however, is there a full-time staff position devoted solely to this function. It is more common to have staff and/or volunteers provide this service along with others such as case advocacy, and information and referral. In some instances staff involvement may be very intense, while in other cases guests will simply be supplied with copies of apartment listings from the Globe or the names of local real estate agents. Much emphasis is placed on encouraging the guests to do as much as possible for themselves.

-- Case Advocacy -- The nature of the guests served in a particular shelter determines the specific types of case advocacy provided. Virtually every shelter director mentioned the need to help women with families get hooked up with AFDC and food stamps. At Parker Street, staff time is invested in helping guests apply for SSI which often provides the only financial support which will eventually enable guests to obtain permanent housing. In family shelters, women or children often have neglected significant medical or dental problems because of their homeless state. Obtaining such services is another major activity of case advocates who may be paid staff or volunteers.

-- Case Management -- Case advocates and case managers are one and the same in almost all shelters. To the extent their roles differ, it would appear that case managers have to put together "packages" of financial support or services. This function is particularly important when a guest has found an acceptable apartment but must also find money for the first month's deposit, furniture and moving expenses.

-- Information and Referral -- The process already described is one in which adult family members are urged to move forward toward independent living. As part of this process, staff and volunteers continually provide information and referral services to the guests, although they are not consciously recognized as such. Several shelter directors during our interviews referred to "teaching" guests how to apply for public housing or "training" guests in the techniques of applying for work. This type of instruction by staff and volunteers is seen as one of the many ways to equip guests for independence.

-- Child Care and Related Services -- A few of the transitional shelters have formally organized day care programs where guests may leave their children while they go out to seek housing or keep other appointments. More commonly an informal staff/volunteer network of babysitters is established as part of the ethic of mutual responsibility already described. When time and funds permit, staff try to back up this informal system by equipping a play room of some type which becomes the center for child care. Some shelters have initiated programs of training in parenting techniques which may include such subjects as nutrition, and homemaking techniques. Almost all shelters seek to have older children enrolled in local schools or try to find ways of arranging transportation for children from the shelter to the school they were attending before the family became homeless.

-- Legal Advocacy -- Homeless families are often in need of legal advice of various types. Battered women, in particular, often need to know what their legal rights are in jointly owned property, what legal steps must be gone through to develop a separation agreement, etc. Families homeless for other reasons need to know what are their legal rights as tenants. All types of families often need legal advice regarding their eligibility for welfare benefits and other public programs. Many transitional shelters provide legal advocacy as part of their program. This may be obtained pro bono through private law firms, through Greater Boston Legal Services or through the efforts of a staff member or a volunteer with legal training.

-- Other Services -- There are a wide variety of services provided by only a few transitional shelters. Formal programs of employment counseling, with related job training when it appears appropriate, have been organized at two shelters for battered women. Mental health programs, providing counseling for those who request it, have been initiated at two of the family shelters and at Parker Street as an integral part of its program. One shelter has a staff competent in several foreign languages and therefore conducts an English as a Second Language course for non-English speaking guests.

The comments previously made regarding emergency accommodation shelters apply here also. A number of shelter directors indicated that the service needs of their guests were not being met because of a lack of paid staff. Of particular concern was the lack of time to provide adequate housing assistance.

D. Comments on Models of Transitional Shelter Programs

The term "transitional shelters," as used in this report, is not intended to replace an equally useful term "transitional housing." Programs which define themselves as "transitional housing" signify that a central tenet of their operating philosophy is that families or individuals may stay (if they obey the rules) until they find a permanent place to live. "Shelters," on the other hand, are places where the individual or family is given a certain number of weeks to stay after which they must be granted an extension or move on.

Most of the 14 programs we have described as transitional shelters limit the period of stay from seven days (Roxbury Corps Center) to eight weeks (Renewal House and Elizabeth Stone). Yet, as the services provided in these programs were examined, we found that they all shared what might be called a "transitional" point of view: A family or an individual was seen to be at a crisis point -- in transition between one way of life and another. The variants among programs were designed to meet differing needs of differing types of guests. But these differences hid deeper similarities.

The programs of the battered women's shelters and the general family shelters focused upon providing the adult guests, mainly women with children, with an environment that would help them become independent and give them practical help by hooking them up with needed services. Most of all these programs focused on helping guests develop a sound financial plan for the future and locating affordable housing.

The Parker Street Shelter, which serves street people, at first seems an anomaly in this group. However, a review of their program shows many similarities between this program and the others. The guests were seen as "in transition" between life in the street and a more stable way of life. Parker Street also focuses on future independence as a goal and upon assisting with the housing search.

The shelters for battered women and the general family shelters deal, for the most part, with women who were already familiar with such basic living skills as shopping, planning meals and money management. Guests at Parker Street either never had such knowledge or skill due to their chronic illnesses or had lost much of it while living on the street. Therefore, a day program teaching daily living skills was made a required part of the program. In effect, the Parker Street staff, in cooperation with the staff of the day program, are training street people to raise their skills to a level which will allow them to live independently. Staff cannot effectively go on to the second step, locating housing and helping guests to move into it, until this has been achieved.

It should be noted that some guests in other shelters, as well, lacked some or all of these daily living skills. This was particularly true of young women with babies who had no experience to draw upon and little or no family support where the knowledge might be acquired.

VI. MEETING DEMANDS FOR EXPANSION AND STRENGTHENING OF THE EXISTING SYSTEM

When this project was initiated, many shelter directors and advocates for the homeless indicated that there was a great need for an accurate estimate of the number of homeless persons and families in Boston. With the cooperation of the shelter community, figures have been obtained which provide a "working estimate" of the numbers of homeless families and persons who seek shelter in Greater Boston each year.

As the research continued, it became clear that these raw figures were not, in themselves, especially significant. Without further interpretation, they could not act as a guide to policy for either the public or private sector. These figures did not suggest how many shelters were needed, where they were needed or how they might be funded. This section of the report is devoted to an exploration of these issues. Here we will also make recommendations regarding the creation of day programs, the development of a more adequate case management system and a system for coordinating the financial resources available to support this expanding service structure.

A. Should the Existing Shelter System be Expanded?

The men and women who direct the existing shelters are of two minds regarding expansion of the current systems. On the one hand, they are saddened whenever they have to turn away individuals or families because of a lack of bedspace. On the other, they are repelled by the idea of a "shelter industry" which would simply provide survival services to more and more homeless persons without addressing any of the economic, political or social problems which underlie homelessness. One advocate told us "what I fear is that we are going to build sheltering institutions which need homeless people in order to justify their continued existence."

The philosophy which has guided the preparation of this report has been one of caution regarding rapid expansion of the existing system. The recommendations which we make will seem, to some, quite surprising in that they are minimal. It is true that these recommendations would not, if implemented, fill every need for beds in the Greater Boston area. They would, however, provide a basis upon which additional growth might later take place.

In all instances, the additional shelters proposed will contain no more than 30-35 beds. This upper limit has been imposed as a result of many conversations with shelter directors over the past year. The shelters newly funded by the Department of Public Welfare have all agreed to limit themselves to this number of beds or to some lower figure. Those larger shelters already in operation must continue to provide service, indeed our community would be in dire straits without them. However, the new shelters being developed should be small community programs, each providing a modest number of beds.

B. A Planning Framework for the Development of New Shelter Programs

In May of 1983, there were 23 shelters operating in the Greater Boston area with a total of 990 beds. Of these, 9 provided emergency accommodations while 14 were transitional shelters.

These shelters receive funds from a wide variety of sources depending upon their sponsorship, history and philosophical outlook. Eight of the 23 programs accept no public funds. The others are funded, in part or in whole, by a variety of public agencies including the Departments of Social Service, Public Welfare and Mental Health. The religious community, individual donors, local foundations and the United Way of Massachusetts Bay also supply significant amounts to the support of some of these programs.

A few shelters are currently contemplating expansion while others feel hard-pressed even to continue operating at their present level. There is no single organization in the public or private sector which has clear responsibility for evaluating the need for expansion of the system as a whole or identifying those communities which are in particular need of additional shelter beds. This is unfortunate since without some locus of responsibility no one, except the governing boards of the shelters themselves, will be responsible for coordinating the decisions regarding expansion and/or reductions of service. All of these shelters will inevitably be in competition for the same pool of public and private monies, which has grown rapidly in the last two years but will probably not grow at the same rate in the future.

The Governor's Office for Human Resources, which has created and staffed the Governor's Advisory Committee on Homelessness would appear to be in a position to address most of the short- and long-term planning issues which lie ahead of the shelter community. This should be done through the structure of the Governor's Advisory Committee in order to assure the participation of persons both within and outside of government.

The most feasible institutional structure would appear to be provided by the Planning Committee of the Governor's Advisory Committee on Homelessness. The Planning Committee brings together most of the major public agencies as well as the chairs of other standing committees of the Governor's Advisory Committee, representatives of various shelter coalitions and of the United Way. We recommend that:

> The Governor's Office of Human Resources should accept responsibility for overseeing development of the existing shelter system and for the coordination of the efforts of public and private agencies so that this development may proceed as efficiently as possible. The Planning Committee of the Governor's Advisory Committee on Homelessness may provide a useful forum for this effort.

This planning framework will never become effective without adequate staffing assistance. While it is often difficult to persuade funding sources to divert resources from direct services to planning activities, it seems vital in this instance. The responsiveness of our community to the needs of the homeless individuals and families requires a thoughtful consideration of the issues of quality of service, location of facilities and efficient application of funds. Therefore, we recommend that:

> The Governor's Office of Human Resources should be provided with sufficient staff to allow it to provide the support which the Planning Committee will require.

C. Present Sources of Financial Support for Existing and New Sheltering Programs

During our interviews, we asked each shelter director "What are your major funding sources?" Public funds, allocations from the United Way of Massachusetts Bay, contributions from the religious community and foundations are major sources of funding.

Shelters obtain in-kind contributions of food, blankets, and furnishings from individuals and from stores, supermarkets and private businesses. These contributions are very important to the shelters since they greatly reduce the amount of cash needed to keep shelter larders stocked and rooms furnished.

By far the most valuable contribution to shelters is made by the volunteers who donate time to the program. Because these volunteers perform so many services which would otherwise be performed by paid staff, the personnel costs of these programs are accordingly reduced. Most shelters include the value of this time as part of their budget.

1. Public Funds

a. Public Welfare (DPW) -- The Department of Public Welfare has for a number of years supported Pine Street Inn and Shelter, Inc., through purchase of service contracts. These contracts were for sheltering and feeding homeless men and women who were presumed to be eligible for General Relief. Money to fund these contracts was appropriated to the General Relief account in the state budget.

In 1982 the Secretary of Human Services indicated that shelters in other parts of the state should also be funded in a similar fashion. Early in 1983 the Boston Family Shelter (as well as programs in Springfield and Northampton) were funded in this way. In June, 1983, the Governor announced DPW funding for operating costs of nine more shelters including three within our research area. These are:

Little Sisters of the Assumption (Project Hope)
Roxbury Multiservice Center
Brockton Coalition for the Homeless

This funding is based upon contracts written with each sponsoring organization. These shelters are supported on the basis of their projected costs.

b. Department of Social Services (DSS) -- In 1976, the State Legislature required the then-existing Department of Public Welfare to provide financial assistance to shelters for battered women. Subsequently this requirement became the responsibility of the newly organized Department of Social Services. This support represents between 30% - 60% of the total cash budget of each shelter.

The DSS also funds the total budget of the Temporary Home for Women and Children. In previous sections we have indicated that this shelter was funded by the City of Boston for many years. When the Commonwealth absorbed all local public welfare programs, it accepted responsibility for this facility as well. It is now operated by DSS employees and all costs are part of the DSS budget.

c. Department of Public Health (DPH) -- Funding for CASPAR Emergency Service Center was originally provided by the federal government through a PIP (Public Inebriate Program) grant to the Division of Alcoholism. This funding has now been discontinued by the federal government but the Division of Alcoholism continues to support the program using other funds.

The Shattuck Hospital shelter was opened in early 1983 staffed by employees of the DPH. All costs are now borne through funds appropriated to the Shattuck Hospital.

d. Department of Mental Health (DMH) -- Funds for the Parker Street Shelter's operating budget are part of the budget for the Lindemann Center. The day program is operated by a private non-profit agency under a purchase of service contract. Staff is paid from funds appropriated to each of the six mental health areas into which Boston has been divided. The DMH also funds one position filled by a person working at the CASPAR Emergency Service Center and one position (psychiatric nurse) working at Pine Street Inn.

In the fall of 1983, new initiatives on the part of the Commissioner of Mental Health promised a significant increase in the number of persons who would be working directly with homeless mentally ill persons.

e. City of Boston -- When the Long Island Hospital shelter was opened in January, 1983, the City Council appropriated no additional funds for its operation. Since then, the Department of Health and Hospitals has received a supplementary appropriation to pay for additional employees, equipment and supplies. In the summer of 1983, the Commonwealth allocated a substantial amount of Federal Emergency Management Agency (FEMA) money to the support of Long Island Shelter.

2. Private Sources of Funding

a. The Religious Community -- Members of Boston's religious community, clergy and lay people, have initiated seven of the shelters serving the Greater Boston area. The Salvation Army developed both Harborlights and the Roxbury Family Shelter. Sancta Maria was founded by a group of Catholic clergy and laypeople. Commonlife was a project of the Jesuit order in New England and is supported almost entirely by donations made through that organization. Project Hope was founded by the Little Sisters of the Assumption, an order of nuns devoted to health care, and is defined as an outgrowth of their concern for the health of young pregnant women. Sojourner House was organized by a group of Catholic clergy and laity concerned with peace and justice issues who saw the need of a family shelter in Boston. Renewal House was originated by members of the Unitarian-Universalist Church.

All of the above mentioned shelters continue to be supported financially by their founding group and are staffed largely by volunteers who belong to or are associated with these religious organizations. In addition, nearly all of the other shelters in the Greater Boston area rely upon churches and religious organizations for financial support and volunteer workers. The various seminaries and schools of religion associated with the universities are a continual source of new volunteers as well.

The Pine Street Inn has recruited church groups to provide evening meals for guests. Each evening a church group arrives at the Inn with the food, prepares it in the Inn kitchen, serves it with the aid of Pine Street staff and does the washing up afterward.

As a result of this program, the Pine Street Inn's food budget is lowered and potential new volunteers are introduced to the Inn. Other shelters have developed special relationships with particular churches who donate clothing, food or supplies on a regular basis. The existing system of shelters would not be in place today if it were not for the type of financial and personal support they have received from Boston's religious community.

b. United Way of Massachusetts Bay -- The Salvation Army, long an affiliate of the United Way of Massachusetts Bay (UWMB), has received funds in support of Harborlights and the Roxbury Corps Center since their inception. Starting in the late 1970's, the UWMB has accepted as affiliates Shelter, Inc., Casa Myrna Vasquez, Elizabeth Stone House, DOVE and Transition House. The United Way has also helped to support creation of Mary Lawson Forman House (by Casa Myrna) and the Boston Family Shelter (by Shelter, Inc.).

c. Foundations and Private Philanthropy -- Most of the emergency accommodation and transitional shelters in the Greater Boston area have received support from local foundations and corporations. This support has been of special importance when shelters have been struggling to open their doors and then to survive during their first year of existence. During our interviews, a number of shelter directors emphasized how important it had been to their survival that various foundations had been willing to respond quickly to critical needs for cash.

CHART FOUR

Sources of Financial Support of Shelter Networks -- Operating Costs

Emergency Accommodations

Name	Private Only	Public Only	Mixed
Pine Street Inn			X
Harborlights	X		
Rosie's Place	X		
Sancta Maria	X		
Long Island Hospital		X	
Shattuck Hospital		X	
Commonlife	X		
Shelter Inc.			X
CASPAR Emergency Service Center		X	
TRANSITIONAL SHELTERS			
Casa Myrna Vasquez/ Forman House			X
Elizabeth Stone House			X
DOVE			X
Transition House			X
Renewal House			X
Waltham Battered Women's Shelter			X
Respond			X
Womensplace			X
Parker Street		X	
Temporary Home for Women and Children		X	
Boston Family Shelter			X
Sojourner House	X		
Project Hope			X
Roxbury Corps-Salvation Army	X		

D. The Future of Financial Support for Existing and New Shelter Programs

The diversity of financial sources reflected in the preceding section may be seen as both a strength and a weakness. The majority of shelters are supported both by grants from one or more public agencies and funds raised from private sources. Shelter directors are well aware of their continual need to raise private funds in order to keep their doors open. Few indicated during our interviews that they felt financially secure.

Shelters newly opened frequently find themselves in a precarious financial position. Three different shelter directors told us that they had originally opened "without a cent in the bank." They had survived their first year only through the generosity of private donors. As a shelter finds its feet, during its second or third year of operation, it becomes recognized by established public and private funding sources who progressively make more substantial contributions to their support. One shelter director said that opening her shelter required a "leap of faith" that the money would come in when it was needed.

In 1983, with significant new funding available from the Department of Public Welfare, a number of new shelters are making that same "leap of faith." A public/private partnership concept has developed for the support of these shelters. In the first year, 75% of their operating costs will be funded by the Department of Public Welfare. In the second year and subsequently, they will receive 50% of operating costs on the assumption that private sector or local government funding will be found to pick up the rest.

Because of the Constitutional restriction on direct aid to the private sector no capital funding from state sources is available to the private, non-profit agencies who will operate these shelters. The Fund for the Homeless, established under the leadership of the Private Sector Initiatives Task Force of the Governor's Committee on Homelessness, has undertaken to provide assistance for capital funding to these agencies.

Many directors of existing shelters, as well as those planning new ones, are concerned about the possibility that the private sector will not be able to meet all the demands which will soon be placed upon it. It appears, in effect, that in 1984 and thereafter the religious community, United Way organizations, foundations and private donors will be underwriting 50% of the operating budgets of these newly created shelters, contributing at least some funds to the operating budgets of the more established shelters, and providing all the money needed for purchase or rehabilitation of buildings used for shelters.

The picture is not entirely bleak. The Fund for the Homeless is receiving significant community support and shelter directors have a history of being ingenious fundraisers in their own behalf. Efforts to obtain contributions of certain goods and services, including the contribution of buildings themselves, can markedly reduce the amount of money which will have to be raised.

In light of the concerns which have been expressed, however, we recommend that:

> Representatives of the private sector, including foundations, corporations, various United Way organizations, the religious community and the Fund for the Homeless should develop a system for monitoring the viability of the public-private partnership which is supporting new and previously existing shelter programs.

VII. THE DEMAND FOR EMERGENCY ACCOMMODATIONS

A. The Concept of Demand

The concept of "demand" for service is a familiar one to human service planners and practitioners. It is generally based upon a count of those currently using a service, coupled with an estimate of the additional number of individuals or families who would use the service if they were able to obtain it. In the case of day care, for example, in a community in which 200 day care slots already exist, a survey might find that 50 more children would be placed in care if the slots could be created and funded. The estimated current demand for day care for that community would be set at 250 slots.

The term "current" in this formulation must be emphasized. Because our research was based upon information obtained from existing shelters in the spring of 1983, it reflects the probable level of demand given the current configuration of shelters. In cities outside of Boston, the creation of even one new shelter will markedly affect the level of demand because it will attract persons who will seek entrance to it. At best, we can only guess at the extent of "demand" which would surface if large numbers of new shelter beds became available.

B. Evidence Regarding the Demand for Emergency Accommodations

Our interviews with the directors of emergency accommodation shelters in Boston and Cambridge revealed that only a few had developed estimates of the total number of individuals -- usually referred to as an "unduplicated count" -- who slept at their shelters in the course of a month or a year. Shelter, Inc., in Cambridge reported a total of 790 individuals in 1982. CASPAR Emergency Service Center reported 446 persons, including 402 men and 44 women, in the same period. Other shelters could not respond or had not been operating long enough to make the question meaningful.

An exception was found at Harborlights in the South End where the director of shelter services has endeavored each month to keep a count of "new faces" so that she could estimate an unduplicated count at the end of the year. Her figures showed 2,763 persons in calendar 1981 and 3,135 in calendar 1982. She stated that at least 65% of these persons were "regulars" who were counted in both years.

In communities outside of Boston, where few services for homeless individuals exist, only indirect evidence of the level of demand could be found. Information from community workers in Waltham suggested that over the course of a year the total number of homeless men and women was, at the very least, 250. In Lynn, the Salvation Army, which rents rooms in local rooming houses for homeless adults, indicated that one to three cases were seen daily in the summer months but in winter the demand ran between three and nine. This suggests a year round demand of between 200 - 250 persons.

In Brockton, where a shelter operated for $2\frac{1}{2}$ months in the Spring of 1983, during 76 nights an unduplicated total of 30 women and 143 men were housed, and there were 98 turnaways. This comes to a total demand, for this limited period, of 271 persons.

On February 25, 1983, the Joint Project on Homelessness sponsored a survey of all the shelters in Boston and Cambridge, as well as the local detoxification centers and one mental hospital inpatient unit. We found that 1,032 homeless men and women were sheltered on that night. Of these only 687 were sleeping in shelter beds. The remainder were sleeping on the floors or stairwells of Pine Street, in detoxification centers, or in the inpatient unit of Fuller Center.

During the winter of 1982-1983, it was a well-documented fact that night after night the Pine Street Inn sheltered between 150-200 men for whom they had no beds. (The actual number on the night of our survey was 199.) When the Long Island Shelter and the Shattuck Hospital shelter opened in January, 1983, the numbers of extra guests at Pine Street dropped substantially, but soon began to rise again as men began to leave jails or hospitals where they had spent the winter.

In the course of the shelter survey, each shelter guest was asked how long it had been since he or she had lived somewhere other than on the street. A total of 668 of the men and 128 of the women answered. The response rate for women was only 71.5% (N-179) while that of the men was 84.4% (N-791).

Approximately 53% of the women who answered and 61% of the men who responded said they had been on the street for over a year. The figures probably underestimate the number of persons who have been on the streets for more than a year. Persons familiar with street life have pointed out that those who did not answer this question were more likely to be those mentally ill or suffering from the effects of chronic alcoholism who, in most cases, have been on the street for years.

CHART FIVE

Homeless Men and Women

Responses Indicating Continual Living on the Street Less than a Year

Response	Women	Men
Less than one month	10	61
1-2 months	7	33
2-3 months	14	30
3-4 months	6	31
4-5 months	4	24
5-6 months	4	11
6-7 months	8	32
7-8 months	--	12
8-9 months	5	12
9-10 months	2	4
10-11 months	--	6
11-12 months	--	2
TOTALS	60	258

Questions asked:

-- When this person had a fixed address, where was it?

-- How long ago was that?

CHART SIX

Homeless Men and Women

Responses Indicating Continual Living on the Street More than a Year

Response	Women	Men
1-2 years	21	97
2-3 years	25	88
3-4 years	12	61
4-5 years	2	35
5-6 years	2	28
6-7 years	--	16
7-8 years	--	13
8-9 years	--	7
9-10 years	1	8
10-11 years	3	18
11-12 years	--	2
12-13 years	--	9
13-14 years	--	1
14-15 years	1	5
15-19 years	1	5
20-plus years	--	17
TOTALS	68	410

At the very minimum, this body of evidence indicates that, in the course of a year the Boston and Cambridge emergency accommodation shelters see at least 3000 - 3500 different homeless men and women. Of these, about one-half to two-thirds are out on the street every single day of the year. The remainder become rehoused in less than a year, use Bridgewater or other institutional refuges as an escape from the street, or move on to other cities. The notion of a "fixed address" for those who use shelters habitually is often "a short-term place to live upon which I have a precarious hold."

In addition, an estimated 750 - 800 persons reportedly seek shelter, or would use shelter in the cities of Brockton (300), Waltham (250), and Lynn (200-250). No figures were obtainable in Quincy or Salem.

Total estimated demand for emergency accommodation shelter over the course of a year in those parts of the Greater Boston area from which we were able to obtain figures is between 3,750 and 4,300 persons a year. This is a minimum figure and does not include individuals who do not use shelters but who sleep in subways, abandoned buildings, or other unprotected places.

C. Recommendations for Expansion of the Emergency Accommodation System

The experiences of last winter have made it evident that additional emergency accommodation beds are needed. Homeless men who come to Pine Street Inn seeking a bed should not have to sleep in a precarious spot on the floor or in one of the stairwells. No one feels this more strongly than the staff and volunteer leadership of Pine Street. However, in the absence of any alternatives the Pine Street Inn has continued to allow as many persons as it can fit within its walls on winter nights.

The emergency accommodation programs which provide shelter to homeless women have historically limited the length of time any woman could remain a guest at any one shelter. (For example, a woman who has stayed seven nights at Rosie's place will be required to be sleep elsewhere for fourteen nights before coming back for another seven nights. Harborlights, Shelter, Inc., and Sancta Maria have similar rules.)

Homeless women refer to these limited-stay shelters collectively as "the circuit" and refer to their method of survival as "living on the circuit." Some have lived on the circuit for years carrying in their heads an accurate calendar of what shelters they must visit in what order to stay within the rules. Others find the physical and psychological effort too difficult and choose to use only a shelter with no length-of-stay rules, such as Pine Street Inn or Long Island, or retreat to the unprotected world of abandoned buildings, subways and hallways.

The directors of the shelters which make up the circuit feel angry and frustrated that homeless women must make this effort just to stay alive. Once again, the lack of alternatives has resulted in the creation of a kind of rationing process.

This sad result has evolved over a period of years. Each shelter on the circuit has its own history and the leadership and staff of each provide in a caring and compassionate way as much as they possibly can to these homeless women.

The only immediate answer for the women on the circuit and the men on the floors of the Pine Street Inn is to establish some additional emergency accommodation beds. But much more than this must be done. In a subsequent section we will advance recommendations for additional transitional shelters, both for families and for homeless adults. These programs should be thought of as intermediate housing where homeless men and women will be able to undergo a more intensive social and psychological rehabilitative experience than they can in any of the emergency accommodations shelters. It is of the highest importance that our community begin to work on the development of such transitional programs for homeless individuals. Only in this way will street people be able to leave the street. Without such programs we will face an ever escalating demand for emergency accommodation beds.

Bearing in mind that new emergency accommodation beds must be created within an overall planning framework (which will include a heavy community investment in transitional programs), we recommend that:

> At least 100 additional emergency accommodation beds for men and 40 emergency accommodation beds for women must be created in Boston and an additional 25 beds for men and 10 beds for women must be created in Cambridge. No shelter will be planned to house more than 35 persons. To the greatest extent possible all these new emergency accommodation shelters will be located in neighborhoods of the cities of Boston and Cambridge not currently provided with emergency accommodation beds. The neighborhoods of Dorchester, Roxbury, and South Boston appear to be communities in which many individuals live before becoming homeless and should be actively considered.

In Brockton, Waltham and Lynn, our research indicated that there are recognizable adult street populations. In Brockton, the Department of Public Welfare has funded a shelter which is being developed by a coalition of private agencies. In Lynn, the Salvation Army presently pieces together private funds from the United Way of Massachusetts Bay and other sources to rent rooms for homeless adults. In Waltham, the Bristol Lodge, a shelter sponsored by several agencies and churches, serves both individuals and families. We recommend that:

> The Governor's Office for Human Resources explore the adequacy of services for homeless individuals in Lynn and Waltham. In both communities public funds might support additional case management staff to follow up and assist persons currently sheltered by existing community based programs. Direct funding, through the Department of Public Welfare, of the present programs or new ones might also be considered.

D. Recommendations Relating to Day Programs to Supplement the Emergency Accommodation System

Our research in Boston and Cambridge and our interviews with homeless men and women in the Shattuck Hospital made clear that there was a great need for day programs in Boston and Cambridge. The Boston Shelter Subcommittee of the Governor's Advisory Committee on Homelessness has advocated for the creation of one or more day programs in Boston as a matter of the highest priority. There are several existing day programs which may be used as models including the Center Club in Boston and the Salvation Army Drop In Center in Cambridge. Some local meals programs are also interested in expanding into a day program.

Day programs are not simply a concern in Boston. In both Lynn and Salem, we found that community workers identified the creation of a day center for homeless persons as, perhaps, an even more immediate need than creation of an emergency accommodation facility.

Given the high level of interest and apparent need for this type of service, we recommend that:

> The Boston Shelter Task Force should continue to plan for the development of day programs in Boston and Cambridge to be funded by both private and public sources.

> The Governor's Office for Human Resources must accept responsibility for planning the creation of day programs for homeless persons in those communities where the need exists but has not been met.

E. Prevention of Homelessness: Policies Regarding Release of Persons from State Facilities

At several points throughout this report, we have mentioned that certain kinds of facilities were providing shelter even though they did not define themselves as "shelters" or present themselves to the community as such. Included among these are Bridgewater State Hospital, Tewksbury State Hospital, the in-patient units of mental health partnership clinics and alcohol detoxification centers as well as Department of Mental Health hospitals. The various correctional institutions operated by the Commonwealth might also be included in this list.

It would appear that to some extent, and possibly to a large extent, unplanned discharges from these various facilities add to the homeless population now seen in Boston and Cambridge as well as the other cities in which we interviewed. We may conclude that there is a large unmet need for "resettlement services" within state government itself. The conceptualization of an adequate resettlement service which could respond to a wide variety of housing needs is not a problem for the Department of Mental Health alone. All of the agencies involved are the responsibility of the Secretary of Human Services. Therefore, we recommend that:

> The Executive Office of Human Services and the Executive Office for Communities and Development should jointly investigate ways in which the twin problems of discharges from state facilities and the development of effective housing alternatives for persons discharged might be best addressed.

VIII. THE DEMAND FOR TRANSITIONAL SHELTER

A. Evidence Relating to the Demand

In the Boston/Cambridge area, there were four family shelters operating in the winter and early spring of 1983. These were the Temporary Home for Women and Children (45 beds), Sojourner House (20 beds), Project Hope (12 beds), and the Salvation Army Roxbury Corps Center (12 beds). In April 1983, the Boston Family Shelter operated by Shelter, Inc., was opened, adding 35 beds to the available supply.

In Brockton, the Catholic Charitable Bureau rents rooms for families in local hotels and motels. Similar programs are operating in Lynn through the Salvation Army and in Salem/Peabody through the North Shore Community Action Program. In Quincy, a local priest occasionally aids families with funds donated by parishioners.

The total number of families housed in 1982 through these programs has been calculated at 462. Chart Five provides details.

We asked directors of Boston-based shelters were asked about the numbers of families turned away because of lack of bedspace. There was a surprising amount of agreement among the directors that between three and five families were turned away a day. They were referred by churches and social agencies as well as area offices of the departments of Public Welfare and Social Services.

Sojourner House was able to supply even more exact figures. In the first year of operation (October 1981 - September 1982), they had logged 899 requests for shelter which they had been unable to fulfill.

Because all of the shelters are full every night and seldom have vacancies, the churches and social agencies seeking beds call each shelter in turn. Therefore, there is a great amount of duplication in the reported demand from shelter to shelter. The Sojourner House figure, however, represents an unduplicated count. For the purpose of calculating total demand in the Boston/Cambridge area, an assumption will be made that the Sojourner Hose figure of 900 families represents a minimum count of those who sought shelter but could not obtain it.

When our research began, it was originally assumed that families from other cities were coming to Boston seeking shelter. However, the overnight survey of the 25th of February indicated that 36 of the 44 families sheltered had last lived in Boston or Cambridge. Interviews in the cities outside of Boston subsequently revealed that families in those communities consistently refused referrals to the Boston shelters.

Except for Brockton, where the 75 families sheltered included all who sought shelter, there are no hard data on the number of families in these cities seeking help. In Lynn and Salem, community workers estimated that they saw 100 to 150 new families a year, while in Quincy the figure was approximately 75. Total demand in these three suburban cities combined would appear to be at least 275 families. (No information was available for Waltham.)

Based on this information, a total estimate of demand in the Greater Boston area will obviously be an approximation. It seems reasonable to suppose, however, that at least 1,600 families sought shelter either in Boston or from one of the suburban programs, a figure which would include the 462 families which actually obtained transitional shelter.

CHART SEVEN

Families Sheltered in 1982

Name of Shelter	Families
Temporary Home	299
Sojourner House	18
Project Hope (estimated)	30
Salvation Army Roxbury Corps	40
Brockton-Catholic Charities	75
TOTAL	462*

* An unknown number of additional families from Lynn, Quincy and Salem/Peabody also were sheltered in 1982.

In addition to these general family shelters, there are eight programs for battered women which operate nine shelters with 141 beds. Estimates based upon the number of families who can be sheltered and the normal length of stay reported by these programs lead to the conclusion that over a year these shelters can accommodate between 470 and 700 families. The exact number will depend upon how quickly families can find somewhere else to stay and how many large families seek shelter.

Information obtained from five of these eight programs indicated that an estimated 630 persons (women and children) were sheltered during calendar year 1982. This was in addition to the 462 families already discussed. This figure included an unknown number of battered women who had no children with them. From the data available, it was impossible to estimate the number of family groups being sheltered.

During the winter of 1983, while these interviews were being conducted, battered women's shelters were turning away potential guests because of lack of beds. Since then, these shelters have developed a simple system for keeping all shelters informed about the current availability of beds. Each month one shelter takes responsibility for making a daily call to all the other shelters in the network to review bed availability. These calls are generally made in the morning. During the rest of the day any of the other shelters may call the coordinating shelter for information. According to several shelter directors this system has increased the efficiency of the entire program to such an extent that actual turnaways occur only rarely.

The only transitional shelter for homeless adults is the Parker Street Shelter which has a bed capacity of 50. Staff estimates that it takes six months for a person to go through the program and to be appropriately placed in independent living or in another program. Therefore, the approximate yearly capacity is 100.

The Parker Street shelter accepts only persons referred from Pine Street Inn and Rosie's Place. These two shelters have developed a waiting list of individuals the staff feels could benefit from this program. In early 1983, there were approximately 200 additional persons on this waiting list. Based on this evidence, the total yearly demand may be set at 300 individuals.

The evidence regarding yearly demand for family shelter is summarized in the chart below.

CHART EIGHT

Transitional Shelters	Level of Demand
General Family Shelter	1,600 families
Battered Women	470-700 families*
Homeless Adults	300 individuals

* estimated capacity

There may be some overlap between the families seeking shelter at the general family shelters and those contacting the battered women's shelters. It is not possible to estimate how great that overlap might be.

B. Recommendations for the Expansion of the Transitional Shelter System for Families

The most restrained interpretation which may be placed upon this data is that in 1982 a minimum of 1,600 families sought shelter from general family shelter programs in the Greater Boston area. Of these, perhaps 500 were accepted into one of the existing shelters or were provided with a room in a hotel or motel. The remaining 1,100 families lived doubled up in transient and unstable living arrangements, squatted in abandoned buildings or lived in other "public places."

This estimated shortfall of 1,100 Greater Boston families who could not be sheltered by existing programs is totally unacceptable. A problem of this magnitude cannot be resolved in a few months. The shelters recently funded by the Department of Public Welfare in Dorchester, Roxbury and Brockton will substantially improve the situation. Nevertheless, more needs to be done. Therefore, we recommend that:

> At least two additional transitional shelters for eight to ten families should be established in Boston and that still another be established in Cambridge/Somerville.
>
> Transitional shelters each serving six to eight families should be established to serve each of the communities of Lynn, Quincy and Salem/Peabody as soon as possible.

All of these shelters should be limited to a maximum of 35 beds. The guidelines developed by the Department of Public Welfare requiring all funded shelters to have staff who would perform case advocacy/management services for each family should be adhered to.

C. Recommendations for the Expansion of the Transitional Shelter System for Homeless Adults

Of all the indicators of immediate need for additional sheltering programs, the most graphic relate to the category of homeless adults. The program of the Parker Street shelter has already been described in this part of this report. We have referred to the fact that Pine Street Inn and Rosie's Place have compiled a waiting list of over 200 persons -- currently living in emergency accommodation shelters and exposed to the manifold dangers of life on the street -- who could benefit from the intensive rehabilitative work provided by Parker Street staff. Yet, because of limitations imposed by staff, physical lay-out and funds, Parker Street can accept only five new cases a month.

The directors of Boston and Cambridge emergency accommodation shelters have indicated their intense concern regarding the mentally ill persons for whom they feel they must take responsibility. They have strongly urged the expansion of the Parker Street program in other locations. However, they have cautioned against creation of large facilities, which could rapidly become warehouses for mentally ill street people. The limitations of 30-35 beds should apply to these programs as well.

It is important to bear in mind the "transitional" ideology of these shelters. They should be thought of as an intermediate step between life on the street and long-term housing. Recommendations to be made in part two of this report will relate to permanent housing programs for persons suffering from chronic mental illness or chronic alcoholism.

Bearing in mind that this is only one aspect of an overall plan for the development of a variety of sheltering programs, we recommend that:

> The Department of Mental Health begin to develop additional transitional shelter programs modeled upon the Parker Street shelter. At least one such program should be located in the Cambridge/Somerville area and four more in various mental health areas of the city of Boston. A minimum of 150 beds are needed in Boston and Cambridge, in addition to the 50 beds already operating at the current Parker Street shelter.

IX. RECOMMENDATIONS RELATING TO CASE MANAGEMENT AND CASE ADVOCACY SERVICES

The description of services provided by emergency accommodation and transitional shelters has stressed the importance of case management/advocacy as a service to the guests. Both individuals and families who are homeless need extensive amounts of assistance in dealing with official bureaucracies. Shelter staff with the proper amount of experience become extremely adept at working out complex service plans.

One of the central problems of shelter directors is their inability to deliver a sufficient volume of this type of service to their guests. In many sheltering programs volunteers perform the bulk of these duties. However, our interviews revealed a growing appreciation on the part of shelter directors that it was impractical to expect volunteers to provide the quality of case management services needed by individuals and families who are homeless.

Full-time paid staff is needed by the shelters because only full-time staff can acquire the information and experience needed to make the "system" work successfully for the guests. Also, by establishing a routine presence in the shelter full-time staff can slowly develop trusting relationships with those guests who are reluctant to ask a succession of different volunteers for help.

Because the need for case management services is acute in many different sheltering programs, we recommend that:

> The Governor's Office for Human Resources, in consultation with specialists in the development of case management programs, and in consultation with case managers now working in shelters, develop a capacity to provide additional paid case management staff to those shelters who need it.

The meals programs, which play such a large role in helping homeless persons to survive in Boston, Cambridge and many other communities, report that their staff is often called upon to provide information, and in the course of serving meals find themselves providing some case management or advocacy services as well. Existing shelters report that staff of shelters newly being created, staff of meals programs and staff of churches and social agencies are continually seeking informal "training sessions" on case management and advocacy techniques.

Conversations in the spring and summer of 1983 with the directors of shelters, meals programs and church groups revealed a great interest in organizing some type of training mechanism both for volunteers and staff, focusing upon case management and advocacy. In the hope of facilitating this process, we recommend that:

> United Community Planning Corporation and the Massachusetts Association for Mental Health in conjunction with the Massachusetts Coalition for the Homeless, the Governor's Advisory Committee on Homelessness, Greater Boston Family Services, the Hunger Hotline of Project Bread and other interested parties should explore the possibility of organizing training programs in basic case management/advocacy techniques for shelter staff and volunteers, the staffs of meals programs and other interested public and private agency staff.

Case management and case advocacy, as it is practiced in the shelter world, is largely concerned with finding ways of obtaining needed services from state and municipal agencies, private non-profit agencies and even from other shelters. In order to perform this function effectively the case managers/advocates must be well informed regarding the current policies of all these organizations, agencies and groups. Shelter staff and particularly the directors of shelters spend a great deal of time simply trying to ascertain what these policies are.

In Boston and Cambridge, because of the large number of homeless persons and families seeking help and because of the large number of helping agencies involved, there is a need for some type of informational resource, similar to that now being provided by Project Bread Hunger Hotline. The role of this service is to coordinate and disseminate information, make linkages between agencies and raise public consciousness regarding hunger issues in Greater Boston.

In all likelihood, a similar service for sheltering programs would have a different set of goals and different responsibilities to the community. In the hope of initiating a service of this type, we recommend that:

> United Community Planning Corporation, the Massachusetts Association of Mental Health, the Information and Referral Office of United Way of Massachusetts Bay, and the Project Bread Hunger Hotline should jointly convene a meeting of shelter directors, advocates and public and private agency staff to discuss the possibility of developing a centralized information service for shelters and sheltering organizations.

PART TWO
HOMELESS MEN AND WOMEN

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I. INTRODUCTION

When this project was conceptualized in the spring of 1982, one of its major goals was to produce for the first time some very rudimentary information about the homeless populations seen in the Greater Boston area. Although shelter directors could provide their impressions about the demographics of the population (age, sex, length of time on the street, etc.), there was no basic information about the populations -- and subpopulations -- which comprise the homeless of Boston and surrounding communities.

The survey of February 25th, involving all Boston and Cambridge shelters, has been described in the Introduction. The material from that survey, including some basic characteristics and demographics of the homeless populations, will be summarized here. We feel it provides a solid basis for the clinical assessment of homeless individuals also described here as well as for future surveys and examinations of the needs of the homeless. The information from the survey should facilitate future research and planning by establishing rudimentary demographic information about the shelter populations.

The survey data deals only with the sheltered homeless of Boston/Cambridge. Although we do not have similar information about the five cities outside of Boston where interviewing for this project was also done, we include here comments from these interviews to illustrate observed similarities and differences between these cities and Boston/Cambridge. Although other cities have come to our attention, like Chelsea, Beverly, Framingham and the Tri-City area (Medford, Malden, Everett), as locations where identifiable homeless populations are known to exist, we did not have the time or resources to obtain data in all these communities. Further research and fact gathering should be done to illuminate the problems of homelessness, individual and family, in these communities.

II. THE ONE-DAY CENSUS: FEBRUARY 25, 1983

The original plan for the survey of the sheltered homeless did not distinguish between homeless men and homeless women. As we proceeded, however, it was clear that there were important distinctions to be made in the analysis of the data for the men and women. Therefore, the characteristics of homeless women and homeless men are, in most instances, presented in separate charts.

On the night of February 25th, there were 1,032 persons sheltered in the various facilities participating in the survey. Unfortunately, 62 forms were so incomplete that not even the sex of the individual was indicated.[1/] For purposes of our analysis, these 62 cases have been discarded. The remaining 970 cases include 179 women and 791 men.

Women were much more reluctant then men to provide information. Almost one-third refused to answer some or all of the questions asked, while approximately fifteen percent of the men refused.

In negotiations with the various shelters regarding their participation in the survey we stressed that we did not want to "hassle" anyone for information. It was more important, we felt, for each shelter to preserve the appropriate welcoming atmosphere in which homeless men and women would feel confident that they would be treated well. This rate of participation was the best shelter staff could obtain and stay within these guidelines.

A. Former Community of Residence

The nineteenth century stereotyped figure of the "tramp" reflected a complicated reality. Historians have pointed out that the number of tramps increased dramatically each time the American economic system went through one of its periodic "crashes" or "panics." These homeless men were, for the most part, urban workers or rural poor searching for employment opportunities.

1/ The shelter at the Lemuel Shattuck Hospital had recently been opened on February 25, and there was inadequate shelter staff on hand to assume the additional task of filling out the forms. In the beginning of the evening (with the consent of the shelter staff), our own volunteers collected this information from the guests. However, the final bed count for the evening at the shelter was 62 persons more than the number who had been seen by our volunteers.

Mixed in with these transient unemployed men was a component which was called "the home guard." These were homeless men who had always resided in the locality in which they were now homeless. They traveled in search of work only to adjacent towns or cities, always returning to the community with which they were most familiar.

Our interviews with directors of the shelters making up the emergency accommodation system indicated that they felt most of their guests were members of the "home guard." In 1983, they are called "regulars." They no longer travel in search of work but search instead for the rudimentary services needed to survive. As we shall point out later in this report, many have chronic mental health and/or social service needs.

Shelter staff were asked to provide an answer to the question "When this person had a fixed address, where was it?" Or, in the case of the Pine Street Inn, obtain an answer to the question, "Where did you live before coming to Pine Street."

Chart One summarizes the answers provided by homeless women to these questions. Chart Two provides a neighborhood by neighborhood breakdown of specific locations. The category "Boston, no neighborhood specified," includes replies such as "in a Boston rooming house" or "with my mother in Boston."

The results tend to support the contention that virtually all the women finding shelter in Boston/Cambridge have local origins. However, since one-third of the women did not respond to the question, this interpretation must be advanced with caution.

Chart Three summarizes the results of this question for the men. Of the 791 men sheltered on that night, 313 (39.6%) last had an address somewhere in Boston. Chart Four shows that Dorchester, the South End, Beacon Hill and Roxbury are the leading neighborhoods.

It should be noted that the Beacon Hill figure was swelled by the presence of twelve men who stated that Beacon Chambers Hotel, which burned in October 1980, was their last permanent address.

Chart Five displays the breakdown of the cities and towns outside of Boston where these homeless men last lived. Since Shelter, Inc., CASPAR Detox, and the CASPAR Emergency Service Center are all located in Cambridge, it is not surprising to find Cambridge and Somerville leading this list. The survey was taken a few days before the temporary shelter in Brockton opened which accounts, in part, for its high standing in this list.

Chart Six lists the state from which 126 (15.9%) of the homeless men came. It is interesting that New York, California and Florida rank high on this list, along with New Hampshire and Maine. However, it is critical to note that a large percentage of these men came to Massachusetts years ago. Although their last "fixed" address may have been outside the Commonwealth, these men are now residents of Massachusetts -- its streets and its shelter system.

Five Cities Outside of Boston

The report of the temporary shelter which operated in Brockton last winter indicated that approximately three-quarters of the person sheltered had families in the Brockton area. It went on to speculate that the number might even have been higher but for the fact that some shelter guests would not discuss relatives.

The director of My Brother's Table in Lynn indicated that at least three-quarters of the regular participants in the meals program came from Lynn. Others in touch with the homeless population confirmed that most were from Lynn, although some were from nearby North Shore communities, including Salem and Peabody.

In Quincy, several informants indicated that homeless men tended to take the Red Line into Boston where they could find shelter and meals.

In Salem/Peabody and in Waltham, where few survival services were available for homeless persons, no information was obtained regarding where persons now on the street came from originally.

Summary

In large measure, the men and women on our streets are members of "the home guard." This pattern apparently applies not only to Boston/Cambridge but to the communities of Brockton and Lynn where the pull of the home community appears strong. Only in Quincy, where services are not available locally and where transportation into Boston is reasonably simple and inexpensive, did we find that Boston's shelters were acting as a "magnet" drawing in homeless persons from the suburbs.

The available evidence suggests that the homeless are not "people from somewhere else" who can be persuaded or forced to return to their previous homes. On the contrary they are, for the most part, making use of shelters and survival services in the communities in which they have their roots.

CHART ONE

Homeless Women Sheltered in Boston/Cambridge
Most Recent Home Community Summary

Community Location	Number	Percentage
Boston	76	42.4%
Cambridge	11	6.1%
Somerville	3	1.7%
Other Mass. Communities (one each)	15	8.4%
Other States	13	7.3%
Other Countries	2	1.1%
No usable reply	59	33.0%
TOTAL	179	100.0%

CHART TWO

Homeless Women Sheltered in Boston/Cambridge
Most Recent home Community-Neighborhoods of Boston

Neighborhood	Number
Boston (Neighborhood not specified)	21
South End	18
Dorchester	14
Back Bay	3
Beacon Hill	3
Roslindale	3
Roxbury	3
East Boston	2
Jamaica Plain	2
South Boston	2
Brighton	1
Charlestown	1
Mattapan	1
North End	1
West Roxbury	1
TOTAL	76

CHART THREE

Homeless men Sheltered in Boston/Cambridge

Most Recent Home Community Summary

Community Location	Number	Percentage
Boston	313	39.6%
Other Mass. Cities	178	22.5%
Other States	126	15.9%
Other Countries	8	1.0%
No Usable Reply	166	21.0%
TOTAL	791	100.0%

CHART FOUR

Homeless Men Sheltered In Boston/Cambridge

Most Recent Home Community -- Neighborhoods of Boston

Neighborhood	Number
Boston (Neighborhood Unspecified)	69
Dorchester	48
South End	46
Beacon Hill	28
Roxbury	27
South Boston	24
Back Bay	20
Jamaica Plain	14
East Boston	13
Mattapan	6
Brighton	5
Hyde Park	4
Roslindale	4
Allston	2
Charlestown	2
North End	1
TOTAL	313

CHART FIVE

Homeless Men Sheltered In Boston/Cambridge

Most Recent Home Community -- Massachusetts Cities and Towns

Outside of Boston

Neighborhood	Number
Cambridge	60
Somerville	15
Brockton	11
Quincy	9
Braintree	6
Framingham	4
Weymouth	4
Lynn	3
Medford	3
New Bedford	3
Revere	3
Waltham	3
Woburn	3
Worcester	3
Arlington	2
Belmont	2
Brookline	2
Chelsea	2
Lawrence	2
Lowell	2
Malden	2
Reading	2
Salem	2
Watertown	2
Whitman	2
Wilmington	2
Other Communities (one each)	24
TOTAL	178

CHART SIX

Homeless Men Sheltered In Boston/Cambridge

Most Recent Communities -- Other States

State	Number
New York	24
California	18
New Hampshire	13
Florida	12
Maine	12
New Jersey	5
Rhode Island	5
Illinois	4
Louisiana	4
Texas	4
District of Columbia	3
Oregon	3
Arizona	2
Connecticut	2
Washington	2
Other States (one each)	13
TOTAL	126

B. Age Description

One of the stereotypes of homelessness is that the men and women on the street are usually elderly. Certain photographs of homeless persons which have received wide currency have shown homeless persons with grey hair who are shuffling along the street apparently bent with age. Despite this image, however, the shelter directors we interviewed indicated that they primarily serve a middle-aged population.

During the survey of February 25th, we requested staff of shelters to provide the ages of guests. In a great many cases the responses were provided by the guests themselves although some were supplied from shelter records.

Homeless Women and Men in Boston/Cambridge

Charts Seven and Eight show the results of the questions regarding age. Because the results show such similar patterns both sexes will be discussed together.

The number of teenagers sheltered is relatively small.[2/] Even the proportion of young adults (age 20-24) was smaller than we expected, 7.3% among women and 6.7% among men.

In our culture, the next two decades of life (25-44) are those in which men and women are expected to establish life patterns, decide upon careers and begin families. In our sample, these two decades provide 78 (43.6%) homeless women and 385 (48.6%) of the homeless men.

The two decades of later middle age (45-64) provide an additional 58 (32.5%) women and 272 (34.4%) of the men. After the age of 55, the numbers of men and women begin to decline on a year to year basis. Persons of retirement age (65 and older) comprise only 3.9% of the women and 7.3% of the men. This is consistent with our interviews with shelter directors who indicated that elderly persons made up only a small portion of the homeless population.

2/ There are several shelters in Boston and the surrounding areas which provide services for runaway and/or homeless children and teenagers. We did not include these shelters in our research. Thus, the figures here on teenagers do not suggest the absence of the problem but simply that we considered the problem one apart from the research at hand.

The Five Cities Outside of Boston

The report from the temporary shelter in Brockton indicated that the average age of all guests was 33.1 years. Over one-third were under the age of 25 while only eight (of 173) were 60 or over.

In Lynn, the Salvation Army reported that they saw "many" men under 20 seeking shelter. Another source in Lynn perceived the population as being "mainly between 20 and 40."

The Quincy population of homeless individuals was reported to range, primarily, between the ages of 18 and 30.

No relevant information was available from Salem/Peabody or from Waltham.

CHART SEVEN

Ages of Homeless Women in Shelter February 25, 1983

Age	Number	Percentage
17-19	7	3.9%
20-24	13	7.3%
25-34	34	19.0%
35-44	44	24.6%
45-64	58	32.4%
65 and older	7	3.9%
Blank or not usable	16	8.9%
TOTAL	179	100.0%

CHART EIGHT

Ages of Homeless Men -- Sheltered in Boston/Cambridge

Age	Number	Percentage
17-19	13	1.6%
20-24	53	6.7%
25-34	206	26.0%
35-44	179	22.7%
45-64	272	34.4%
65 and older	58	7.3%
Blank/not usable	10	1.3%
TOTAL	791	100.0%

C. Prevalence of Alcoholism and Psychological Problems

During our interviews, shelter directors often stated that many homeless persons suffered from mental illness. Those who had been providing shelter for several years stated that they have been seeing increasing numbers of mentally ill persons in the shelters and on the streets.

Traditionally, alcoholics have made up a large portion of shelter populations. We found that this continues to be true. The census forms suggest a variety of alcoholics among the homeless -- some are on or between "binges" some have character disorders, some have psychoses and some, as one program director described, suffer from "wet brain."

For this question, shelter staff were asked to place a check mark next to the term "Alcoholic" if it applied to an individual, and to place a check mark next to the term "Psychological Problem" if they felt that that term applied.

No attempt was made to define either of these terms. Shelter directors were asked to instruct their staff to assess each guest on the basis of their own observations, or their previous knowledge of them. The responses, then, reflect an impressionistic assessment by staff. The results of a clinical evaluation of a sample population, a more accurate assessment, will be discussed in the next section of this part.

Homeless Women in Boston/Cambridge

The results are displayed on Chart Nine. There were 27 (15.6%) women for whom the word "Alcoholic" was checked off. In 106 cases the term "Psychological Problems" was checked off. This represents a very high percentage (59.2%) of the cases.

Both terms were checked off in eight cases. By establishing a separate category for these eight cases we obtain the distribution shown in Chart Ten.

The needs of alcoholic women, while reportedly fewer in number, should not be ignored. One shelter director pointed out that while she saw relatively few, the alcoholic women she knew were "extremely deteriorated" by the time they started using the emergency accommodation shelters. Often, she said, they had been maintained and protected by families while their drinking increased and they became progressively less able to function. Eventually some sort of crisis, often the loss of a "family protector" through death, separation or divorce, resulted in forcing such women onto the street. There, she was particularly unequipped to cope, both because of her alcoholism and lack of street knowledge of available survival services.

Homeless Men in Boston/Cambridge

The results of the overnight survey of homeless men in shelters is displayed in Charts Eleven and Twelve. The staff of the shelters felt that in 407 (51.5%) of the cases the term "Alcoholic" might be applied to a guest. In 224 cases the term "Psychological Problems" was checked off which represented 28.3%.

Chart Twelve suggests that there was some overlap between these two categories. In 50 instances, both terms were checked off.

Five Cities Outside of Boston

A key figure in the organization of the temporary shelter in Brockton indicated that she was surprised that they did not see more of the continually homeless as guests. Another observer guessed that 10-15% were mentally ill. Also mentioned, as a distinct category, were alcoholic middle-aged men who had been under treatment at the local Veterans Hospital and now were on the street in Brockton.

In Lynn, there was an unanimous agreement from all informants that mentally ill persons composed the bulk of the street population. One said she saw many clients unable to function on their own. Another estimated that 70% of the homeless individuals he saw were mentally ill.

One observer in Lynn reported that she continued to see a relatively small but identifiable population of alcoholic women and drug addicted women who lived on the streets or in rooming houses but regularly sought financial assistance or other types of help. While most of these were "regulars," an occasional new case appeared who fit this category.

In Quincy, the priest who has until recently been providing shelter for individuals indicated that 25% of the persons who came to him had mental health problems. Another observer in Quincy described the street population as including prostitutes, criminals and drug addicts as well as alcoholics.

In Salem, the organizers of a local meals program identified most of their regular guests as chronically mentally ill or alcoholic. An observer in Peabody reported seeing 6-10 newly homeless alcoholics a month in the caseload.

The proposal for a shelter in Waltham describes the basic population to be served as alcoholic or mentally ill. The local deotxification center suggests that approximately 90 homeless alcoholics are known to this agency alone. The area office of DMH estimates that five mentally ill individuals a week lose their apartments or rooms each week for one reason or another.

Summary

The findings of the overnight census supported, for the most part, the subjective impressions of the shelter directors. The prevalence of mental illness is a reality and that reality is brutal for homeless individuals who, under the best of circumstances, are faced with an endless array of difficulties and are often hard-put to survive. The following section looks more closely at the issue of mental illness.

We have repeatedly emphasized that this survey population is drawn from Boston and Cambridge. It should be noted that the impressionistic reports from Lynn, Salem and Waltham also portray their homeless populations as primarily composed of persons suffering from mental illness or alcoholism. The communities further away from Boston may exhibit quite different patterns. In Brockton, for example, the guests at the temporary shelter were reported to be primarily unemployed young men without major mental health problems or other handicaps.

CHART NINE

Homeless Women Sheltered in Boston/Cambridge
Staff Assessment of Alcoholism or Psychological Problems

Alcoholism:	Number	Percentage
Yes	27	15.1%
No	14	7.8%
Blank	138	77.1%
TOTAL	179	100.0%

Psychological Problems:	Number	Percentage
Yes	106 *	59.2%
No	10	5.6%
Blank	63	35.2%
TOTAL	179	100.0%

* In three instances the word "possibly" was written next to the words "psychological problems." These three cases are included in the total of 106.

CHART TEN

Homeless Women Sheltered in Boston/Cambridge

Cross Tabulation of Staff Assessment of Alcoholism and Psychological Problems

	"Psychological Problems" Indicated		"Psychological Problems" Not Indicated		Total
"Alcoholism" Indicated	8	(4.6%)	19	(10.6%)	27
"Alcoholism" Not Indicated	98	(54.7%)	54	(30.1%)	152
TOTAL	106		73		

CHART ELEVEN

Homeless Men Sheltered in Boston/Cambridge
Staff Assessment of Alcoholism or Psychological Problems

Alcoholism:	Number	Percentage
Yes	407	51.4%
No	10	1.3%
Blank	374	47.3%
TOTAL	791	100.0%

Psychological Problems:	Number	Percentage
Yes	224 *	28.3%
No	8	1.0%
Blank	559	70.7%
TOTAL	791	100.0%

* In 11 instances the word "possibly" was written next to the words "Psychological Problems." These 11 cases are included in the total of 224.

CHART TWELVE

Homeless Men Sheltered in Boston/Cambridge
Cross Tabulation of Staff Assessment of Alcoholism and Psychological Problems

	"Psychological Problems" Indicated		"Psychological Problems" Not Indicated		Total
"Alcoholism" Indicated	50	(6.3%)	357	(45.1%)	407
"Alcoholism" Not Indicated	174	(22.0%)	210	(26.6%)	384
TOTAL	224		567		

III. MENTAL HEALTH NEEDS

A. Identification of Need: The Clinical Survey

It has been clear for the past several years that a significant portion of the population making use of emergency accommodations have a need for mental health services. In this section, we will document the need for these services and outline some aspects of specific mental health services which impact persons who are poor and emotionally disturbed.

Directors of emergency accommodation shelters stated in all of our interviews that large numbers of the guests who are using their accommodations are mentally ill. In the cities of Boston and Cambridge, the interviews provided rough estimates of 50% at Pine Street Inn, 60% at Rosie's Place, 75% at Harborlights, 50% at Sancta Maria, and 50% at Shelter, Inc., in Cambridge. These percentages included, in some instances, people in need of counseling to deal with severe situational crises as well as people with chronic emotional problems.

In the previous section, we described the February 25 census when shelter directors were asked to assess whether or not individuals staying at the shelters had "psychological problems" and, in those instances, to note it on the census forms. On that evening, 1,032 individuals were staying in shelters and other sheltering programs. Of that number, 316 (31%) were affirmatively assessed by staff as having a "psychological problem." As many forms were returned incomplete we felt certain that 31% was an accurate baseline count, but it was neither a complete count nor a real understanding of the nature of the psychological problems.[3/]

Many questions remained unanswered as the data from the February census was examined: What is the extent of mental illness among homeless individuals? What are the illnesses? Are they chronic or situational? What services and supports are needed? Why are people not getting them? Have these individuals been part of the state's mental health system? And, has that mental health system provided appropriate care?

3/ It should be noted, once again, that this was not a clinical evaluation. Rather, it was the impression of the staff and volunteers on the night of February 25. The statistics presented in this section, we feel, provide a more accurate assessment of mental health needs among the homeless.

To address these questions, a clinical needs survey was carried out at the Lemuel Shattuck Shelter during the week of April 25, 1983.[4/] This population represented the best available sample of sheltered homeless people in the Boston/Cambridge area. The information gathered from these clinical interviews is divided by category for the sake of discussion: Demographics, Shelter Use, Medical Problems, Psychological Problems, Job Status, and Support Systems.

1. Demographics

The median age of this homeless population was 33.8 years, with a range from 4 to 68 years. Eighty-three percent were male and 17% female. Their races closely reflected the Boston population: 77% white and 22% black (the remaining 1% was Hispanic). Only 11% were currently married; 41% were single and 48% were either divorced, widowed or separated. Approximately 20% of this latter group became homeless after their marriages dissolved. Forty-eight percent of the entire group had one or more children and half of them saw their children regularly. The shelter group as a whole was relatively educated: 31.2% had a partial high school education or less, 37.5% were high school graduates, and 31.2% had some years of college or were college graduates. (See Chart Thirteen).

2. Shelter Use

For many guests, homelessness was a way of life. Forty percent had been on the streets for six months or longer, and half of this group for more than two years. During the time of the study, almost 70% of the guests used the shelter virtually every night. Another 24% slept at the Shattuck shelter intermittently. Only 5.6% were first-time users. Of the entire sample 85% frequented other shelters, particularly Pine Street. A small group of young men were chronic drifters who had recently arrived in Boston from other communities.

4/ The data in this section ("Identification of Needs") is taken from a report entitled "Summary of Clinical Data on the Homeless" which was prepared as part of the overall MAMH-UCPC project. The clinical study was designed by Ellen Bassuk, MD, and the summary was written by Ellen Bassuk, MD, and Alison Lauriat. Special thanks should be given to the following clinicians who helped with the data collection: Ellen Bassuk, MD; Lenore Rubin, Ph.D.; Stephen Schoonover, MD; Martin Kelly, MD; Willian Kantar, MD; James Donovan, Ph.D.; Jane Eckert, MSW; Bernard J. Carey, MSW; and Stephen Washburn, MD. In addition thanks must be given to Lenore Rubin, Ph.D. for her help with the data analysis.

3. Medical Problems

The clinical survey included basic questions about the physical well-being of the guests at the state-run shelter. The results showed that 44% reported having major medical disorders such as heart disease, high blood pressure, ulcers, emphysema, asthma, and severe cellulitis. Of these guests with medical problems, only 54.8% had received appropriate medical care. Many had difficulty following medical instructions or keeping follow-up appointments. For example:

> A middle-aged man with severe mental illness had chronic cellulitis of his leg, making it difficult to walk without crutches. His leg was enlarged, edematous and infected. Unfortunately, he also has a severe mental disorder and falsely believed that childhood cerebral palsy had caused his leg problem; he claimed that leaning to the left would correct the imbalance in his walk. This belief interfered with his capacity to care for himself appropriately and to follow medical instructions. His mental illness, however, remained untreated.

Other guests were also unable to care for themselves. Although the staff was aware of some of their problems, medical screening was not mandatory which meant that some people received no care. Approximately 10% of those interviewed had potentially life-threatening problems.

4. Psychological Problems: Major Mental Illness, Alcoholism and Character Disorder

The findings of the clinicians confirmed the perceptions of the shelter directors that many of their guests suffered from mental illness. In fact, the majority of this sample at the Shattuck shelter had severe and chronic psychological difficulties (see Chart Fourteen). These persons were not recent casualties of our economy; their illnesses were long-standing and profound. No doubt, their situations were not helped by the recession, but their problems were more basic and personally disorganizing.

Among the psychological problems, at least 39.5% had major mental illnesses of psychotic proportions. This included 23 schizophrenics (30.3%), 4 manic-depressives (5.3%), and 3 depressives (3.9%). Another guest, a former resident of Belchertown State School, was severely mentally retarded. Of those with serious mental illness, women were over-represented, accounting for one-third of the total.

Of our entire sample, approximately one-third (27.9% to 35.5% depending on whether we include the mentally ill who were too disorganized to answer questions) had been previously hospitalized for psychiatric reasons. (See Chart Fifteen) Of the overall sample, 13.2% had been hospitalized more than once, 23% had been in state facilities, and 7.3% had been hospitalized for a total of more than one year. These include 73.3% with major mental illness and 26.7% with chronic alcoholism. As shown by scores on the Global Assessment Scale (GAS), these guests experienced more severe difficulties in most areas of their life (85% scored 40 or less on the GAS) than the overall shelter population.

The majority of these homeless mentally ill persons are currently receiving no psychiatric treatment. Only four were on antipsychotic medications -- two on lithium and two on antidepressants. Only four were currently in supportive psychotherapy, and three in aftercare. Their past history of psychiatric treatment often showed little or no treatment.

These statistics, however, tell only part of the story. Many of the schizophrenics were so disorganized that they were unable to phrase even a few sentences coherently. Their stories were disjointed, rambling, unreal, at times grandiose, and almost always difficult to follow. Their general confusion most certainly interfered with their ability to work or to participate in even the most routine daily activities. Their behaviors suggested that at this time in their illness, they require intensive care; providing them with only a job and an apartment is not sufficient and, perhaps more to the point, not appropriate given their needs.

> A 16 year old boy sent to the shelter from DSS was too frightened and paranoid to accept help. Each time it was offered he ran away; now the staff keeps their distance. He has become a regular shelter user, but remains isolated and withdrawn.

> An 18 year old boy was enrolled in an Ivy League college until he became schizophrenic. He was briefly hospitalized in a state facility and started on long-acting intramuscular antipsychotic medication. For a while his mother was able to care for him, but she too is troubled. He now wanders the streets muttering and talking to himself, responding predominently to voices. He is frightened, confused, and unable to communicate coherently.

Both of these young individuals need protection and treatment. They have only become sick recently and have not been successfully engaged or treated by the mental health system. Under these circumstances, their prognoses are extremely poor. At the least, they should be provided with living conditions that ensure human dignity and that effectively offer refuge.

Individuals as sick as these have a right to treatment. This can and should be offered in a non-threatening fashion by persons skilled in working with those who are suffering from mental illness.

Another 22 persons interviewed (or 28.9%) were chronic alcoholics. Of this group, five also had a secondary diagnosis of psychoses -- raising the percentage with major mental illness to 46.1%. Two of the alcoholics were also addicted to drugs. The chronic alcoholics, in contrast to the psychotic patients, were more involved in various treatment programs. They rotated rapidly through the detoxification centers, into the shelters and back. More than 50% of the total number of alcoholics had been detoxified at some point in their alcoholic careers and one-half of this group during the previous year. The average alcoholic in this group was detoxified six times. Forty percent of the total number of alcoholics were currently in Alcoholics Anonymous. Their stories were compelling.

> A chronic alcoholic male had lived on the street for more than 20 years. During adolescence he ran away from home where he was physically abused. He had been in and out of mental hospitals, detoxification centers, and jail. During the last year, he made multiple serious suicide attempts. He was recently discharged from a city hospital for pulmonary tuberculosis. Despite the ravages of illness, he was still able to tell his story in a manner that conveyed both his desperation and terror. Although he erects almost impossible obstacles to help, he transmits a powerful wish to be magically rescued. He is only 33 years old.

Sixteen (or 21%) of our sample were labeled personality or character disorders. Although these people did not have a psychosis, they had major difficulties forming and maintaining relationships and holding steady jobs. Many have had problems with the law. For example:

> A 17 year old boy was raised by an alcoholic father and a neglectful, depressed mother. He had a long history of difficulties: in school he received poor grades, got into many fights and finally stopped attending classes. He then became involved with drugs and alcohol which interfered with his efforts to remain employed. He was repeatedly fired. Finally, he developed a severe depression and was admitted to a psychiatric hospital. However, he was discharged to the care of a social worker after only three weeks because he was unable to follow hospital rules. Not surprisingly, he repeated the same pattern with the social worker. Again, he was unable to conform to the structure of treatment; this time he refused to go back. He then fought with a policeman and ended up in jail.
> He now lives on the streets and in the shelters -- fighting frequently and having difficulty following the rules. His family refuses to speak to him, he is angry at his social worker, and he is again starting to feel depressed. He said about his life: "I just go from day to day. If I really thought about it I wouldn't want to be alive. I usually just feel numb."

This boy is still a teenager, but he has already fallen out of nearly all society's systems that are set up to nurture, support, heal and rehabilitate.

Many of the homeless described general feelings of passivity, helplessness, apathy, and numbness. The Brief Psychiatric Rating Scale (BPRS),[5/] a symptom scale, indicated a surprisingly large percentage did not experience feelings of anxiety, tension and depression. Most certainly, the perils of surviving in the streets would generate anxiety, depression and fear in most people -- unless they are too overwhelmed by concerns about their survival and too emotionally hurt to allow themselves the luxury of experiencing feelings.

A small group (9.2%) were not given any psychiatric diagnosis. These included children and adolescents who were in the shelter with their parents and a few men who had just arrived in Boston and were expecting to begin work within several days.

5. Support Systems

The homeless are one of the most disenfranchised populations in our society. Diagnostic groupings and symptom constellations reflect only two dimensions of their difficulties. To determine how troubled and disabled this population really is, we evaluated their degree of isolation and disconnection from support networks. (See Chart Thirteen) Most of us are surrounded by family and friends, people at work, and if we have fallen on hard times, by professional caretakers from various social agencies. We would expect that at the least, this needy, chronically ill population can depend on social institutions to care for them. In contrast to this expectation, the reality is quite dismal.

Only 18 (28.5%) were involved with a social agency. These included two at the Veterans Administration, two at mental health agencies, one with CETA, three with welfare, two with Bridge Over Troubled Waters, one with the Department of Social Services, one with the Massachusetts Society for the Prevention of Cruelty to Children, one with the Massachusetts Rehabilitation Commission, one with OIC, one with an agency for elderly alcoholics, and a family of three with the Roxbury Dental and Medical Group.

5/ Overall J., Gorham D.: The Brief Psychiatric Rating Scale. Psychological Report 10:799-812, 1962.

Even more remarkable was our finding that 74% had no family supports and 73% had no friends to provide support. Forty percent of the total shelter sample claimed they had no relationship with anyone -- not even a social agency, staff member, or shelter friend. The deinstitutionalized group were even more disconnected: over 90% had no support from friends or family.

6. Job Status

The current employment status of the shelter guests was also bleak. About 74% were unemployed. Of the remainder, 17.6% had temporary or odd jobs while about 3% sold their blood or became subjects in medical studies. Only 4 (5.9%) worked steadily. Within the previous two years, one-third had never worked; of those who had, most worked at odd jobs that they changed frequently. These jobs were generally unskilled and included the following: cooking, construction, delivery, dishwashing, factory work, car washing, and auto mechanic.

Given the high rate of unemployment, it is not surprising that 36.8% had no source of income. Approximately 29% earned pocket money from odd jobs, particularly from the labor pool, or from participation in medical studies. Only 22% received public welfare benefits. These included General Relief (11.8%), SSI (4.4%), SSDI (2.9%), and AFDC (2.9%). The remaining 3% had other sources of income such as family. Paralleling these figures, 71.8% had no medical insurance, 19.7% were on Medicaid, 1.4% on Medicare, 4.2% had private insurance and the remainder had VA benefits.

7. Overview of Findings

Many of the questions posed at the outset were answered through this clinical study.

Mental illness is indeed pervasive among the homeless. The mental health system, although it has touched the lives of some of these guests, is not reaching many in this population. Individuals who have been diagnosed are not currently receiving the services and support they need, while others have never even been evaluated by mental health professionals.

Although when asked, almost three-quarters of the guests stated that they expected to get off the streets by finding a job and a place to live, this answer must be understood within the context of their individual needs and the limitations of the caretaking system. Despite the motivation and the good intentions of planners and government officials who would like to offer just such services, the data show that this would hardly suffice. The chronicity of the illnesses of these homeless persons suggest that the verbalized intentions are incompatible with capabilities -- unless constant support, stability and care are also provided. Almost half had serious medical problems. Based on our findings, we can conclude that almost all homeless persons require humane living situations, medical care, and extensive psychosocial services. Without provision of a sophisticated combination of services which take into account the special characteristics of this population, the plight of the homeless will continue to be desperate. Given this need for a full range of services, both intense and expensive, it is certainly appropriate to consider whether or not society really wants to provide them and to pay for them.

CHART THIRTEEN

Demographic Description of the Sample

Sex			
	M=65		83.3%
	F=13		16.7%
Age			
Median Age	36.4 Years		
Range	4 years - 68 years		
Race			
	N=60	White	76.9%
	N=17	Black	21.8%
	N= 1	Hispanic	1.3%
Marital Status*			
	N=30	Single	41%
	N= 8	Married	11%
	N=35	Had been married	48%
Educational Level			
	N=20	Partial H.S. or less	31.2%
	N=24	H.S. graduate	37.5%
	N=20	Some college or degree	31.2%

* 47.8% of the sample reported having one or more children.

CHART FOURTEEN

Diagnostic Groups
N = 76

	N	Percent
Major Mental Illness: (Total = 39.5%)		
Schizophrenia	23	30.3
Bipolar affective illness (manic depression)	4	5.3
Unipolar affective illness (depression)	3	3.9
Mental Retardation	1	1.4
Character or Personality Disorder	16	21.0
Chronic Alcoholism*	22	28.9
No Diagnosis	7	9.2
TOTAL	76	100.0

* 5 chronic alcoholics carried a secondary diagnosis of major mental illness; 2 chronic alcoholics carried a secondary diagnosis of drug addiction (e.g., heroin).

CHART FIFTEEN

History of Psychiatric Hospitalization
N = 68

	N	Percent
Previous Hospitalization	19	27.9%
Number of Hospitalizations:		
Single	10	14.7%
Multiple	9	13.2%
Type of Facility for Most Recent Hospitalization		
State	15	22.1%
Private	2	2.9%
VA	1	1.4%
Other	1	1.4%
Total Length of Time Psychiatric Hospitalization		
6 months or less	10	14.7%
7 months to a year	0	0
1 year or more	5	7.3%
Undetermined	4	5.9%

CHART SIXTEEN

Formal and Informal Support Systems

	N	Percent
Job Status	68	
Employed	18	26.5%
Temporary jobs	12	17.6%
Blood/Experiments	2	3.0%
Steady Employment	4	5.9%
Unemployed	50	73.5%
Financial Status	68	
No Income	25	36.8%
Odd Jobs	20	29.4%
Public Assistance:	23	33.8%
General Relief	8	11.8%
SSI	3	4.4%
SSDI	2	2.9%
AFDC	2	2.9%
Others	8	11.8%
Insurance Status	71	
None	51	71.8%
Medicare	1	1.4%
Medicaid	14	19.7%
Private	3	4.2%
VA	1	1.4%
Other	1	1.4%
Family and Friends		
Family Support	70	
Yes	18	25.7%
No	52	74.3%
Support from Friends	62	
Yes	17	27.4%
No	45	72.6%
Social Agencies Involvement	63	
Yes	18	28.6%
No	45	72.4%

B. Chronic Mental Illness

The findings of the interviews conducted at Shattuck Hospital place in a new light many of the original questions raised about the mental health system. Despite the fact that in Boston and Cambridge there are a multitude of mental health programs, largely supported through Federal and State funds, this homeless population seems to be virtually without service.

The need for quality services that are both stable and caring is critical to the long-term well-being of a population afflicted with major mental health problems. The long periods of time which this population has spent on the streets or in shelters suggest that their problems are chronic.

The nature of schizophrenia as a chronic illness makes manifest the needs for special care and underscores the inappropriateness of "normal shelter life" for homeless mentally ill persons. After acute phases of the illnesses (during which time persons require intense care and hospitalization), there are many residual symptoms.[6/] All of the following were seen at the Shattuck Shelter: social isolation and withdrawal; diminished capacity to function in traditional roles (e.g., as an employee, wage earner, or student); and an impairment in the ability to care for oneself (e.g, health and hygiene).

Given the number and variety of symptoms observed, it is striking that only two persons in the entire sample had any ongoing relationship with agencies providing mental health services. Further, only 19 persons interviewed at Shattuck had ever undergone psychiatric hospitalization. A portion of these were persons with less severe diagnoses (personality or character disorder or alcoholism). In fact, some of the most seriously ill had never been hospitalized at all. The clinical survey demonstrates that there is a significant population in the shelters who need mental health services and who are not getting them. More importantly, they need the supportive services (food, clothing, sense of belonging) and the stability that having a home provides.

6/ American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, (Third Edition) Washington, DC, 1980.

Life in a shelter, such as the Shattuck, is the antithesis of what is essential for those with chronic mental health needs. According to the literature and mental health professionals interviewed, care for the chronically ill must include stability -- a patient knowing, at a minimum, where he can sleep, eat, and spend his days. It must also include continuity of care -- a patient being familiar with and trusting those around him, including the care providers. And care must be predictable and reliable -- assuring that the patient will be able to stay, will be able to get the services he needs, and will be able to come back if, after venturing out, the patient needs the care again.

To assess what kinds of mental health care is, in fact, being provided, we conducted a series of interviews with personnel in each of the area offices of the Department of Mental Health serving Boston and Cambridge. There we attempted to ascertain how existing services were structured and how these services did or did not meet the needs of the homeless.[7/]

7/ Several of the interviews in this section were conducted by Carol Anderson, who volunteered her time through the Massachusetts Association of Mental Health and provided much assistance in the preparation of this report.

C. Caring for the Homeless Mentally Ill: The Services

Although much has been published in professional literature about caring for the chronic mental patient and much has been written of late about caring for the homeless, the academic community has said very little about those homeless persons with chronic mental health needs.

The excerpt below suggests that much still remains to be resolved relating to the care of chronic mental patients:

> Since the colonization of this country, there has been a shifting of responsibility for the chronically mentally ill among various social levels. Their care was traditionally assumed by the family until the development of county almshouses, at which time they were housed with other social deviates including debtors, the poor, and the multiply-handicapped. Dorothea Dix is widely heralded as the leading advocate for removing the chronic mental patient from county facilities and encouraging their care in rural mental hospitals funded by the states -- the intention of which was to improve their lot. However, with urbanization, immigration, and changing social mores, these facilities soon became as shameful as those they were designed to replace; and scandals about state hospitals have been commonplace for over half a century. An important impetus behind the community mental health movement was the desire to provide more effective and humane care for the chronic mental patient, but the gap between the intentions of the Mental Health Study Act of 1955 and the implementation of the federally-funded Community Mental Health Centers Act of 1963 has been sizeable, resulting in continuing neglect of chronic mental patients. To compound our current situation, the rapid and unplanned exodus of half the inhabitants of state hospitals between 1963 and 1973, euphemistically termed deinstitutionalization, has resulted in the shift in location of the chronically mentally ill without a concurrent shift in programs, resources, or governmental responsibility.8/

When these people are homeless in addition to having chronic mental health needs, the situation appears to be even more difficult.

8/ John A. Talbott, MD., "What Are the Problems of Chronic Mental Patients - A Report of a Survey of Psychiatrists' Concerns," Ad Hoc Committee on Chronic Mental Patients, The Chronic Mental Patient: Problems, Solutions, and Recommendations for a Public Policy. American Psychiatric Association, Editor: John A. Talbott, MD, Washington, DC, 1978, p.1.

1. The Attitude Issue

Caring for the homeless mentally ill is difficult, immensely expensive, both in terms of time and resources, and very often frustrating for mental health service providers. Repeatedly during the interviews in the area offices we heard about how difficult it is to provide services to this group of individuals.

At the Dr. Solomon Carter Fuller Mental Health Center in the South End of Boston, a director of a program which deals with homeless persons described the population as a group of 500 to 1,000 individuals who float from one shelter to another, from one mental health facility to another. He said: "As a clinician, you don't know how to deal with these people. There's nothing we can offer them. They have to tell us what they want. There's no gratification to working with them. They're smelly and retractive. We're not trained to deal with these problems."

Although the specific quote is from one person in this instance, the same sentiment was echoed in other interviews. Other workers described homeless clients as "difficult people" or as "not endearing" and frequently workers expressed their frustration with clients or patients who "just don't get better."

Another source of frustration among mental health workers is the difficulty of making successful referrals. In some instances, it relates to the issue of appearance. An administrator of the Parker Street Shelter program noted: "If you are dressed okay and look okay, you can go anywhere. You can get access. Mentally ill people living on the street are constantly denied access because they cannot and do not look and act okay."

Further, it appears that some mental health professionals will not refer certain clients to certain programs at all. These referrals would, it seems, jeopardize the mental health workers' relationship with various agency personnel. One case worker told us: "I won't make a referral to Shelter, Inc., unless I know the person is appropriate .... I've got a reputation there." Those most ill, disheveled, or unbathed clearly have their options limited for them both by their own appearance and by the unwillingness of case workers to waste "good referrals" on them.

2. Financial Assistance: Can it support community care?

Persons who are both homeless and mentally ill are not economically viable in our society. Except for day labor and some other very poor-paying jobs, they cannot obtain work and in many instances are simply not qualified for work. Many are too disorganized or demoralized even to try. Given this fact, the general public often assumes that homeless men and women are supported by public welfare benefits of one type or another.

During our interviews with shelter directors early in the project, the point was repeatedly made that homeless men and women are often totally dependent upon shelters and meals programs for their very survival. The extent to which this is true was brought home to us by the finding that of 78 persons interviewed at Shattuck, only 23 were receiving any type of public assistance.

Throughout the interviews in the area offices, a common frustration was voiced about the efforts and time it takes to get a needy, mentally ill person connected with financial assistance. For persons who require in-patient care, the problem is exacerbated by the current regulations governing General Relief and SSI which require persons to be dropped from the assistance rolls during hospitalization.

Staff of the Fuller Center reported that it takes about six weeks for people to re-obtain the assistance they had before entering the in-patient unit and that the length of in-patient stay is increased because of this. For persons who lost rooms or apartments during their hospitalization, the process "is all but impossible" because the welfare department has required, until very recently, that all General Relief recipients have addresses.

The problem of an address, however, is only the beginning of the difficulties the mentally ill experience when seeking to obtain or retain General Relief. The amount of subsidy is very small. An average recipient, according to our interviews, gets less than $200 per month. That amount cannot pay for even the most economical types of housing (e.g., residential foster care) and does not come close to paying for more expensive accommodations. Further, if one is lucky enough to find a room for $45 or $50 per week, there is no money left to pay for food, clothing or medications.

For the homeless mentally ill person, the matter of medication is extremely serious. In 1973, the state eliminated many of the medical benefits for General Relief recipients. For the chronically mentally ill population, this move was devastating. A long-term schizophrenic often needs daily medication for the rest of his life. But that medication is often not covered by any public assistance monies. If a person is lucky enough to have an inexpensive place to live (e.g., with family or friends) and able to buy medication with the general relief allotment, there is still no coverage for any hospitalization which arises. As was noted in the interviews at the Shattuck Shelter, this population has an extremely high incidence of medical problems.

While their monthly allotments are more realistic, recipients of Supplemental Security Income (SSI) and Social Security Disability Income (SSDI) are plagued by other problems. The approval process is becoming extremely difficult and recipients are regularly being dropped for no apparent reason. From many different mental health professionals in the Greater Boston area we heard the same thing: For recipients of these federal programs, the stresses of being dropped and going through the appeal processes compound existing mental health problems and in some instances lead to re-hospitalization.

A clinical social worker at Lindemann Center described the current situation with SSI as he sees it. He said: "If someone is together enough to go through the hoops it takes to get on and stay on SSI, that person probably shouldn't qualify to be on it!" The reality of course, at Lindemann and elsewhere is that people are not together enough to get on and stay on. These very time-consuming bureaucratic functions are being performed by staff. In fact, in at least one mental health center, one person's job description consists entirely of helping patients obtain SSDI benefits.

As has been shown, this population has severe psychological disabilities and cannot provide financially for themselves. Yet, our research suggests that the public sector programs to provide financial assistance do not adequately reach those most in need -- the homeless, destitute, and psychologically impaired.

3. Inpatient Policies: Census and Discharge to the Streets

While the difficulties of providing care to the mentally ill homeless and the degree of poverty of this population are both major barriers to service, an even more significant one is found in the discharge policies followed by some psychiatric hospitals. Mentally ill persons living on the street are not homeless by choice. The term "choice" implies that there are a series of viable alternatives and that an individual has made some type of decision regarding them. In Boston and Cambridge, however, the bleak reality is that alternatives for mentally ill persons do not exist. There is constant pressure to discharge people from inpatient units and to keep the census down. Adequate housing which would be appropriate for this population does not exist in the community in the quantity needed.

The number of people in the in-patient units of psychiatric facilities who are there because there is simply no appropriate place to discharge them is testament to the problems of housing the chronically mentally ill. At the Fuller Center in the spring of 1983, staff estimated that 35 to 40 persons who could be moved out if there were a place to go. The average daily census there is around 70. At the time of the interview, in the Cambridge/Somerville unit at Metropolitan State Hospital there were close to 60 people out of 109 who were ready to be placed in the community if adequate and appropriate facilities were available. At Massachusetts Mental Health Center, 50% of the area patients discharged from in-patient intensive care go to a transitional facility in the center's gymnasium (the Fenwood Inn). At the Lindemann Mental Health Center, staff estimates that 85% of the patients hospitalized are either homeless when they are admitted or become homeless (lose their living quarters due to such reasons as failure to pay rent, eviction, etc.) during their in-patient stay.

Interviews at other area offices, including the West-Ros-Park and Dorchester-Mattapan offices, indicated that there was more extensive care in various community-based programs and less time spent waiting in-patient for community placement. Outside of Boston, the interview at the Met-Beaverbrook Mental Health Center showed similar efforts in the community.

This backlog of persons who wait in the inpatient units for an appropriate placement clearly creates pressure for less than optimal discharge plans. In the interviews with shelter directors, we were told that patients are sent regularly from certain psychiatric facilities directly to the shelters. Although shelter directors feel that this is a totally inappropriate discharge plan, they also feel there is little they can do about it without being inhumane to the patients. Several interviews with mental health area personnel confirmed the practice. In one instance, a director of screening in Boston told us: "I'm not supposed to refer clients to shelters. It's against DMH policy. But I have to tell people as they are discharged that they need to find shelter. I suggest to them that they ask one of the other folks in our programs who is living at Pine Street Inn where to go. If someone says to me, 'You mean I should go to Pine Street?' I have to say, 'No, I didn't say that.'"

At another Boston area program, we were told that DMH employees "make every effort not to discharge to the streets" but that if the patient refuses services offered and the staff feels he/she is "street-wise," then they will just let him go. They also said that if the patient refusing services is not street-wise, they strongly encourage him to stay at the in-patient facility or to accept being placed at one of the boarding houses under their auspices.

In the Cambridge-Somerville program, housing is an extremely difficult problem. We were told by workers in this system that shelters are one of the options used for a discharge plan. We were also told that in some instances, particularly for a young person "pink-papered from Harvard Square," the discharge form simply says "the streets of Cambridge."

4. Living in the Community: A Multitude of Approaches

Our interviews in the shelters and in the mental health area offices suggest that there are a multitude of programs and policies to assist the mentally ill who have become homeless. But the sum of programs available simply does not answer the problem as a whole for the community. The numbers of mentally ill homeless staying in shelters, such as the Pine Street Inn, are evidence of the inadequacy of the overall community response.

Before considering the various publically-funded alternatives, however, the availability of low-cost housing -- or rather its unavailability -- must be considered. For those well enough to rent a room or apartment the task of securing such a place is monumental. We have already pointed out that the great majority of homeless mentally ill persons either have no income or are dependent on public welfare. If they are leaving a state hospital they must begin the process of applying for General Relief, Supplemental Security Income or Social Security Disability Income.

With dwindling supplies of low-cost rooms and apartments, it is hardly surprising that persons with serious mental disabilities are having extreme difficulty finding and maintaining places. In the clinical interviews at the Shattuck Shelter, it was clear that many of those with mental illness were fall-outs from private sector housing. There is not enough of it, it does not afford the emotional supports that many of the homeless need, and it is far too often unaffordable.

In the public sector, there are some ideas, approaches and programs, several of which will be mentioned below, which should all be considered carefully as the community develops a better response in the weeks and months ahead.

For example, in the Cambridge/Somerville area the mental health program, using private subsidies, rents rooms at the local YMCA or YWCA where patients coming out of the hospital can stay for several weeks while they begin the process of getting hooked up with financial assistance. During this time a more permanent living situation is sought.

In this mental health area, as in others, there are cooperative apartments operated by a group called Cambridge and Somerville Cooperative Apartment Project (CASCAP). A worker in the ambulatory care services expressed a sentiment that seems to be felt in all the areas when he said: "Getting into CASCAP is harder than getting into Harvard." In other areas, the number of such sheltered placements simply do not begin to meet the numbers of the mentally ill who need such placements.

Another model of community-based housing is the residential foster care program. It is used very successfully in some areas -- notably Dorchester-Mattapan and West-Ros-Park Mental Health Centers. There are 100 beds in the Dorchester-Mattapan program. Clients, who have had previous psychiatric hospitalization, pay $220 to $250 per month directly to the family with whom they reside while the center provides supervision, liaison with the family, and day programs. The director of this program feels that were it not for these placements, these clients would be in nursing homes or on the street.

In speaking with the persons at West-Ros-Park who are responsible for a similar program, it became clear to us that securing and maintaining this housing involved an immense effort on the part of the staff of the Mental Health Center. But, the results made the effort worthwhile.

In all of these interviews, mental health personnel described a range of housing alternatives which are required to provide for the variety of needs seen among their clients. In West-Ros-Park, this range was described as a continuum and included, at the most protected end, a facility (Alternative House) that has round-the-clock nursing and attendant staff for the most psychotic and non-placeable persons from in-patient wards; other components included half-way houses, residential foster care, staffed apartments, and at the least protected end, cooperative apartments. Even with all these alternatives, West-Ros-Park must constantly work to expand its supply of housing.

The West-Ros-Park Mental Health Center has a system of case management and continuity of care that provides ongoing support for its clients in both health and illness. An outpatient worker is assigned to every inpatient and becomes the client's clinician/ advocate/ case manager. The worker is supported by a case management team which can assist in planning, linking, monitoring and advocacy. From interviews we received the sense that personnel in this system are constantly working to create new places in the community. If there is anyone in the community to whom a client can be sent, this will be done with support and assistance provided by the staff. Housing options are constantly being considered in order to enlarge the existing supply. Relationships with area landlords are nurtured and respected so that when clients are placed in a building each landlord knows he can call to get assistance if the need arises. Although, like all other area mental health centers, there is a shortage of housing options for mental health clients, West-Ros-Park's well-organized methods seem to be a positive step in the right direction.

In the Massachusetts Mental Health Center area there is an enormously wide range of housing opportunities for mentally ill persons. This network of supervised residential settings including halfway and quarterway houses, cooperative apartments and independent living facilities has been built up over the years through the efforts of Massachusetts Mental Health Center staff and through the cooperation of many community organizations. At the time this report was compiled, there were 156 places in this housing network for mentally ill persons and an additional number for the developmentally disabled as well. The Massachusetts Mental Health Center also operates the Fenwood Inn, a treatment center and transitional facility. An estimated fifteen percent of those leaving Fenwood Inn go into the housing system described here.

The 50-bed Parker Street Shelter, which is located in the gymnasium of the Lindemann Mental Health Center, operates outside the traditional structure of the Department of Mental Health. Staff have been carefully selected for their interest in working with the homeless. The budget includes funds drawn from the budgets of all other Boston areas. In effect, it is a shelter which serves the entire city without regard to geographic boundaries.

We feel that Parker Street is the best available model of an effective program for the homeless person who is chronically mentally ill. Vital to its success has been the fact that all new guests are selected by a committee which includes members of the staff of Pine Street Inn and Rosie's Place. Acceptance to the program is voluntary and persons may leave if they wish, although few do.

The length of stay is flexible and people do not move out until they are ready and until suitable housing is available. Average length of stay is about six months. It is administered by an Advisory Committee composed of representatives from community programs, mental health programs, and shelters. The annual cost to the state is roughly $300,000 (excluding maintenance, rent and heat).

The staff at the shelter see chronic homelessness as a secondary symptom to serious mental illness, and the program offered to guests reflects this philosophy. Emphasis is placed on establishing stability of relationships with the guests, each of whom is assigned a case worker from the mental health center they came from, a counselor from the shelter, and a counselor from the day treatment center. Thus, there is always someone for a guest to talk with who is familiar with that guest's situation.

When guests are ready to leave the transition is a gentle one. Many guests continue in the day program at Lindemann after leaving and then, only when they are ready, make a transition to a day program in their area. People are encouraged to come back and visit the shelter and shelter workers frequently go out to check on former guests in their new homes. Shelter staff are available to help guests and former guests cope with the red tape involved in obtaining financial assistance. While in the shelter, guests are taught about putting aside money for food and rent so that when they get hooked up to SSI or General Relief they will be able to make use of it.

There is a strong sentiment among shelter directors that the Parker Street shelter is providing extremely important services to its guests and several area workers described the very positive changes in former clients who were guests at the Shelter. However, they also expressed a wariness. One Lindemann Mental Health Center worker described the Parker Street Shelter as "a cop out" and a way of getting around the real problem which, as he sees it, is that "DMH clients aren't getting half what they need to get from the state." He went on to describe that need as "humane care" and that "DMH has a responsibility to provide housing for its clients as well as supervision and monitoring of the clients in the housing settings." His comments mirror those of others who focus on the need for DMH to begin to think about and care for the whole client, where he eats and sleeps as well as where he receives treatment.

5. A Commitment to Change: Looking Ahead

The attitudes of many mental health professionals put the mentally ill homeless person at a disadvantage. The housing programs that provide sheltered or supported housing are inadequate, and as a result mental health workers use the in-patient units, the shelters, and the streets to respond to these needs. If the person is fortunate enough to obtain financial assistance, it is apt to be unreliable if it is SSDI, too low and not covering medical needs if it is General Relief, and anxiety provoking in both instances in that continuity is by no means assured. And, if a person needs re-hospitalization, financial assistance will end and the process to obtain financial aid must begin anew.

This non-system of community response has been inadequate. Planning within the mental health community -- particularly the state's Department of Mental Health -- must begin and must recognize the illness, its chronicity and the corresponding need for stability, reliability and continuity of care.

The recently appointed Commissioner of the Department of Mental Health has made it clear that he is committed to providing mental health services for homeless people. In October, 1983, he announced a plan to provide services within the City of Boston. Most important was the Commissioner's announcement that any person who was mentally ill and was in need of treatment was the responsibility of the Department whether or not he or she had a permanent address.

There are many people in the Boston area shelters who have profound and often chronic mental health needs. Some of them have, in the past, been part of the state's mental health system. Others have roamed the streets, moving from shelter to shelter, and have never been offered the kind of assistance by mental health professionals that they need. Virtually all of these individuals have massive needs. For the most part they have no money, no home, no support network, no ability to hold down jobs or independent living arrangements, no insurance to provide medical care, and no hope for any of these in their future.

Both society in general and the mental health profession more specifically have found ways to ignore the plight of these people. The most recent move to build more shelters is a humane step, and perhaps the only way that emergency accommodations can be provided to a large number of people. However, unless the development of new shelters is accompanied by the development of full and proper supportive services, appropriate for persons mentally ill, shelters could become re-institutionalization without any effort toward communitization. Shelter directors have repeatedly stressed that housing alone will not solve the problem of homelessness, particularly for the mentally ill homeless. Translating that emphasis into action is of the utmost importance to the proper care of this desparately needy population.

The homeless mentally ill is a population no one wants to care for. In those few places where it is now being done, it is expensive; it consumes immense personal and financial resources. Politicians, program administrators, and professionals alike seem unwilling to commit those resources. But it is time, in our civilized society, that we begin the process to truly care for, in an appropriate fashion, those who cannot care for themselves. It is with this in mind that the following recommendations are written.

6. Recommendations

Focus must be taken off "hospital census" which forces inappropriate discharges and inadequate follow-up and/or aftercare. Instead, focus must be placed upon quality long-term care in the community. The Department of Mental Health must provide those who are chronically ill with the basic supports needed to live (adequate housing, food, clothing, and a sense of belonging to a community) as well as psychiatric assistance.

The DMH should initiate a policy pertaining to the chronically mentally ill that includes a recognition of their dependency upon support systems: their difficulties accommodating to change; their need for stability; their tendency to have aspirations and goals that exceed their realistic capacities; their difficulties engaging in treatment and care programs; and their difficulty in disengaging from them.

The policy should initiate an attitude of acceptance and a willingness to be of help as opposed to an attitude of finding a rationale to exclude individuals from service.

The civil rights of individuals should not be a reason that justifies non-treatment. Access to hospitals must become available for the voluntary patient. A state hospital system available only to those dangerous to themselves or others excludes many who need hospitalization because of their serious mental illness and who would be privately hospitalized if they had more resources.

In making this recommendation, we emphasize that we do not advocate any form of reinstitutionalization or large-scale "warehousing" of chronic patients. Instead, we support community-based intervention and community-based rehabilitation services. Thus, we recommend that:

> The Department of Mental Health should establish a system of case management to oversee the delivery of all needed services to the mentally ill who are currently residing in the Boston area shelters.

The development of this case management system should be preceded by the development within each area of an administrative structure which supports the network of community-based services and aggressively uses outreach techniques to link patients with community services provided by agencies outside of the mental health care system.

It should be added that a system of case management, no matter how well organized, is only as effective as the line staff. These case managers face many frustrations since it is well known that some clients continue to resist all efforts to assist them. Indeed it is just these clients who use up a tremendous amount of the time and patience of case managers.

Nevertheless, much can be accomplished and, in fact, is being accomplished by devoted case managers who are well trained and are supported by leadership determined to make case management systems work successfully. There are examples of such successful programs of case management operating in the City of Boston and in other parts of the Commonwealth.

The current residency requirements and geographic restrictions on services do not work for the mentally ill who move around the shelter circuit. For case management to be effective, there needs to be centralized coordination. We recommend that:

> The Department of Mental Health should establish in its Central Administrative Office a Services Planning Unit for Homeless Persons which will be responsible for overseeing and coordinating programs for this population throughout Massachusetts. One of the major responsibilities of this Unit

will be to establish and maintain open two-way channels of communication between the shelter community and the Department of Mental Health. Another function of this unit should be to establish hotlines or make an arrangement through which shelter staff can obtain information or request assistance in emergency situations.

There are many homeless mentally ill in cities outside of Boston. In the cities of Salem, Lynn, and Waltham, we were told that the mentally ill constituted a major component of the local street populations. In those locales, there is a need for transitional type facilities to begin to provide needed care and services. Not completely knowing the extent of need outside of Boston and Cambridge, we recommend that:

The Department of Mental Health, through the Services Planning Unit, begin an area by area analysis of the need for transitional shelters, following the Parker Street model. This survey should be developed in conjunction the Governor's Office for Human Resources which should develop an overall plan for shelter expansion.

In Part I of this report, we discussed the need for additional transitional shelter beds in Boston and Cambridge. This recommendation would enable the Department of Mental Health to ascertain the needs in the other areas.

While we recommend that the transitional shelter system be expanded in Boston, and perhaps in other communities as well, this policy would be pointless unless other alternative housing programs are increased at the same time. Therefore, we recommend that:

The Department of Mental Health develop and expand new housing programs for its patients. These should include, for example, the purchase by the Department of rooming houses, nursing homes or similar facilities to be operated by private non-profit agencies under contract to the Department.

In addition, we recommend that:

The Department of Mental Health and the Executive Office for Communities and Development should review ways through which these new housing programs may be funded. Revision and expansion of the existing Chapter 689 program is one possibility. Another is borrowing through the Massachusetts Housing Finance Agency or a new agency created for this specific purpose.

In conjunction with these proposals for new housing, we must emphasize again the importance of appropriate plans for discharge from state mental health facilities. We recommend that:

> No man or woman should be released from inpatient units to the streets or to shelters. Appropriate options must be provided along with the follow-up and support services which can only be a reality if a case management system is established in each mental health area.

It should be added that patients who have voluntarily committed themselves to mental health facilities have a legal right to leave and that it is commonplace for patients to take advantage of this right. In no way does our recommendation undermine this right.

Nevertheless, staff of various mental health programs freely -- and sometimes casually -- stated during our interviews that releases "to the street" and "to shelters" took place despite the fact that present Department of Mental Health regulations do not allow such releases. In a great many of these cases the patients were not "demanding their legal right to leave" but rather had requested help in finding a place to live. That this help was not forthcoming reflected a lack of workable housing options in the community in question.

The provision of adequate care for the most destitute and needy requires enormous amounts of time, commitment and compassion. For the most part, experience has shown that unless careful monitoring is done the mental health system, as it is presently organized, administered and funded, has little motivation to devote enough of its resources to its most needy clients. Therefore, we recommend that:

> The Massachusetts Association of Mental Health should periodically evaluate the needs of the homeless population, the services available and the progress made toward implementing these recommendations.

In the past the Department of Mental Health has failed to meet the needs of this population and has also failed to assume a strong advocacy position. A change in attitude about services to the homeless mentally ill would constitute a fundamental reversal in policy by the public sector. This change must come from the top down. Governors, cabinet members, Commissioners and legislative leaders all must be persuaded that the need is critical and that the cause is just. Such a change can only come about when there is continual and effective advocacy on behalf of those who cannot advocate for themselves.

IV. OTHER NEEDS: FINANCIAL ASSISTANCE, MEDICAL CARE AND HOUSING

The findings of the previous section underscore the profound problems faced by most homeless individuals in Boston. For a large portion of sheltered men and women in the city, the need for appropriate, stable and caring basic services underlies everything else. For these persons, the notion of becoming self-supporting and living independently is remote. This chapter should be read with this in mind.

Contemplating which needs and services should be mentioned in what order is a little like contemplating the chicken and the egg. Financial assistance will not be effective unless there are adequate and appropriate housing alternatives available. Housing alternatives are not really viable for many in the homeless population unless there are adequate supports available -- day programs, case management for multiple problems, and follow-up on many of the placements. So many of the services are interconnected in terms of the needs, but the reality is that they have little or no relation to each other in terms of the bureaucracies, regulations, and continuing care.

We begin with financial assistance because the poverty of individuals and families who are homeless is so pervasive that it seems best to make it the first order of business.

A. Financial Assistance for Homeless Persons

Adequate income is an essential part of any plan to get off the streets, but the public sector financial assistance programs do not satisfactorily reach the populations of the shelters.

1. General Relief

One shelter director described General Relief benefits as "a stipend for homeless people . . . it is a way to have some spending money while living on the street." At the time of our interviews, General Relief benefits for individuals hovered around $200 per person. A five percent increase has since been enacted into law. Even with this increase, however, the amount is inadequate to provide for shelter, food, clothing and other expenses for a person who cannot provide these things for himself. In order to receive General Relief, a person must be medically evaluated and found to have a medical impairment which makes employment impossible.

General Relief recipients, those who are homeless as well as those who are not, have only certain medical expenses covered. The Department of Public Welfare indicates that visits to private physicians, outpatient clinics and prescriptions for some pharmaceuticals are covered by medical benefits. In-patient care in hospitals and many drug prescriptions are not covered. When an illness is serious enough to require emergency hospitalization, General Relief recipients tend to receive "free care" the costs of which must be absorbed by hospitals.

In practice, General Relief recipients who are homeless, and especially those who are both homeless and mentally ill, have little grasp of which medical services they may obtain with their medical coverage and which are not covered. Staff of shelters indicated that their attempts to obtain needed medical services were frustrated by inconsistent interpretations of confusing Departmental regulations. Shelter directors expressed particular concern about the lack of coverage for drugs which kept the symptoms of mental illness in check. One told us of a young man who uses his entire General Relief check each month to purchase such medication. He eats all his meals at shelters or at some of the church sponsored meals programs and sleeps in shelters. By maintaining his medical regimen, he functions reasonably well but is kept so busy surviving that he has no energy to devote to getting off the street.

There is plentiful evidence that among the men and women staying in emergency accommodation shelters, the proportion of welfare recipients is low. For example, at Rosie's Place, staff estimated that perhaps 25-30% of guests received financial benefits. At Long Island Hospital Shelter, while there was no precise figure, the director told us most guests had no benefits whatsoever. At the Shattuck Shelter, where guests were asked about their financial status, we found that only 25% received any kind of public assistance.

Despite the inadequacy of General Relief benefits, they are obviously better than no benefits at all. No outreach program has been designed to initiate General Relief applications. Furthermore, the system of application, eligibility determination and re-determination now in effect makes it almost impossible for most homeless persons to pass unaided through the bureaucratic steps which lead to enrollment in the General Relief program.

Although General Relief is designed in part to help those with serious mental health problems, it is extremely difficult for recipients to retain this assistance. Frequent or periodic hospitalizations can be expected for this population, and yet the regulations stipulate that when a person is hospitalized, his or her General Relief stops. The application process must then start all over again after discharge. Workers in mental health agencies as well as shelters spend extraordinary amounts of time trying to work through General Relief applications and re-applications for chronically ill patients who repeatedly go through this cycle.

In discussing financial assistance with shelter directors, we found that many guests need assistance in managing whatever public welfare benefits they receive. With General Relief, there is no formal way to provide this assistance through a representative payee. An informal network of shelter staff and members of the religious community have provided this assistance -- cashing checks, helping to plan budgets and serving as "bankers" for homeless men and women -- but it continues to be a need.

Because the benefits to be paid to homeless men and women under the current General Relief program do not provide a realistic financial base which will allow for renting a room and buying food, shelter directors and advocates feel that the basic benefits should be increased. However, there are many administrative and legal issues relating to General Relief which must be addressed in concert with increases in benefits. Among these is the question of whether a special category of grant should be developed for General Relief recipients who are currently homeless. Another is whether or not the current voucher system (which provides half a month's benefits to homeless persons as an advance toward room rent) actually works for the benefit of the recipients.

Because of the complicated nature of these administrative and legal problems, we recommend that:

> The Department of Public Welfare establish an Advisory Committee on Homeless General Relief recipients. This Committee should include representatives of the shelter community, advocacy groups and food programs as well as staff of other human service agencies in direct contact with homeless men and women. This Committee should recommend to the Commissioner a realistic General Relief budget for homeless persons and make recommendations, as well, regarding legal and administrative issues relating to implementing this budget. It should also make recommendations regarding the ways in which the housing voucher program for persons not yet eligible for General Relief might best be administered.

General Relief recipients are not presently covered for hospital in-patient services. This means that in-patient treatment is not accessible to many General Relief recipients unless they can obtain free care. General Relief recipients must also pay for many of their own medical prescriptions. Among homeless General Relief recipients, this lack of coverage has caused much suffering. Therefore, we recommend that:

> The state budget to be submitted in January, 1984 includes a request for funds to provide Medicaid coverage for in-patient care and prescriptions for General Relief recipients, and that the Legislature enact this request. We further recommend that the Department of Public Welfare change existing regulations to implement this change.

General Relief recipients hospitalized for mental illness lose their eligibility during the period when they are living on an in-patient ward. Benefits cannot again be received until release. In practice this means that staff of mental health agencies and shelters must continually re-establish eligibility. Therefore, we recommend that:

> When a person who has been a recipient of General Relief is ready to be released from an in-patient unit in a mental hospital, a process should be initiated in advance of discharge which will make a check for one month's benefits available. This will enable the patient or his case manager to negotiate advance payment of rent. We also recommend that the process of re-establishing eligibility be simplified for persons who have been hospitalized.

Some recipients of General Relief, Supplemental Security Income, and Social Security Disability Insurance have difficulty managing their funds. This is a particular problem for homeless persons suffering from mental illness. Therefore, we recommend that:

> The Executive Office of Human Services explore the possibility of establishing a system of representative payees to assist recipients of public welfare benefits in managing their incomes. Mental health professionals should be consulted as part of this process (as well as administrators of public welfare programs).

2. Federally Supported Financial Assistance

The Federally supported programs known as Supplemental Security Income (SSI) and Social Security Disability Income (SSDI) both provide recipients with more realistic monthly incomes which can help them move out of shelters and into more stable situations. However, in the last two years the Federal government has instituted a system of eligibility redetermination for both of these programs which has resulted in many persons being dropped from the rolls.

Directors of shelter programs and mental health programs all indicated that both the removals and the processes used to implement them -- notification by mail with a complex explanation of the appeal process available to the client -- have been devastating to recipients. Some persons responded to the receipt of these mailed notifications by giving up their apartments and going back on the street even before the cutoff was official. The system which should be helping to keep people from becoming homeless was actually creating more homeless persons. In some instances, the trauma from this experience resulted in re-hospitalization in a mental health facility.

Because of these federally mandated reviews of eligibility for both Social Security Disability Income and Supplemental Security Income, there has been an increase in the number of persons seeking help at Boston and Cambridge shelters. Both chronic alcoholics and those suffering from chronic mental illness have become homeless because they have lost their benefits. Standards which are being imposed appear to violate federal case law relative to the redetermination of eligibility. The Commonwealth has taken legal action which has not yet been resolved. Therefore, we recommend that:

> The Secretary of Human Services and other appropriate officials continue to press the case against the Federal Government regarding the speed-up in re-determining case reviews and both the Governor and the Massachusetts Congressional delegation should continue to oppose the Administration's position on this matter.

B. Medical Care

Medical care is another need. The clinical survey showed that medical problems are prevalent among the shelter populations but that, for the most part, homeless people have no medical insurance and little access to regular or continuing care. As noted elsewhere, Medicaid covers homeless individuals who are SSI, SSDI, and AFDC recipients and Medicare covers those over 65. However, most homeless people are not recipients of these federal programs.

Without access to insurance and regular medical care, homeless individuals look for other alternatives. They use the emergency wards at Boston City Hospital, at the Massachusetts General Hospital (MGH), and at a few other facilities to care for their most acute problems. It is clear that waiting for medical problems to become acute in order to obtain treatment is not sound medical practice. Also, this system is not economically feasible for the hospitals which have open door policies for their emergency wards.

The present system is becoming increasingly difficult for the Massachusetts General Hospital. The Director of Social Services there reported to us that last year MGH provided $12 million in free services. That figure has doubled in just three years. The number of homeless people seen there has also increased dramatically. In a study done in the mid-70's by the Social Services Department, only one person who was homeless came to the hospital for services during a month-long period. Now an average of 200 homeless people seek treatment at the hospital each month!

The problem of how to handle this number of persons at MGH is compounded by the extent of needs. The Director of Social Services noted that about one-half of all the persons who use the emergency ward have social problems more prominent than the medical symptoms which bring them in. For the homeless population who use the emergency facilities, instead of "one-half" the figure is "nearly all." The medical staff works with the social services staff to try to meet the range of needs presented by homeless persons at the emergency wards.

Boston City Hospital also sees large numbers of homeless individuals and now provides shelter, as well as health care, at the Long Island facility. According to a social worker in the hospital emergency room, budget constraints at the hospital itself have reduced some service, but the Long Island Shelter has filled in by taking some of the "chronic ones." It was our sense that the problem of how to care medically for the homeless had been shifted from Boston City Hospital to Long Island Shelter.

The Pine Street Inn operates a clinic to provide for the health needs of its guests. On the night of the census in February we found that the clinic also serves persons not staying at the Inn, but also those living in housing in the neighborhood or on the streets. The Pine Street Inn clinic suggests to us that homeless men and women actively seek good services when they are offered and are accessible. Indeed, the clinic is an example of accessible medical care delivered prior to an acute need arising.

The Governor's Advisory Committee on Homelessness has recently established a Task Force on Medical Care to consider ways in which homeless persons can obtain access to inpatient and outpatient medical care. Because the work of this Task Force is just beginning, this report will make no recommendation in this field beyond that relating to coverage of in-patient care for General Relief recipients.

C. Housing Homeless Persons

There are men and women who live on the streets of Salem and Lynn, Quincy and Brockton, Boston, Cambridge and Waltham. Where shelters are available, they are used intensively. But there are always more homeless people than there are shelter beds which inevitably means that there are always some persons sleeping outside.

One of the most persistent myths about homeless men and women is that they "want" to live on the street. It is certainly true that some of those who continually sleep in shelters have, over a period of several years, developed a daily routine within which they feel personally secure. But in our interviews with homeless men and women at the Shattuck shelter, virtually all stated that they wanted to get off the street and into a more conventional living situation.

Despite these often expressed wishes, it was also clear that many of these homeless men and women were not, in fact, capable of living alone because of chronic mental illness. In addition, they were handicapped by their extreme poverty and the lack of practical alternatives to living in shelters.

In Massachusetts and throughout the nation many community mental health programs have developed halfway and quarterway houses which have been intended to serve as temporary homes for persons leaving mental health in-patient facilities. Federal funds have supported these programs as well as a similar network of halfway houses for alcoholics. However, these facilities ordinarily place a time limit, usually six months, on the period during which individuals may stay. The ultimate goal is to place an individual in some type of independent living situation where he is truly "on his own."

During our interviews shelter directors and advocates repeatedly told us of persons now living in shelters who had been "in one halfway house after another" and who did well in each of them but failed subsequently to adapt to being placed in a room or apartment where they had to function on their own. These stories were about persons suffering from chronic mental illness and those with primary diagnosis of alcoholism.

The results of these interviews and our knowledge of experiences with similar populations in other cities has led us to conclude that "independent living" in the usual sense is not a feasible goal for many homeless men and women and that, in planning for them, it should be replaced with a goal of "living in protected housing." This term means some type of permanent housing where an on-site live-in "caring person" is always available to help the residents deal with personal crises, physical ailments and the vicissitudes of daily living.

The present network of emergency accommodation shelters cannot provide the type of protected environment which many homeless persons need. No one is more aware of this than the directors of the emergency accommodation shelters. Presently all they can do is try to help some individuals obtain a room from some sympathetic landlord. At times a staff person or volunteer is able to visit the individual after he or she is settled to give additional support.

The Parker Street shelter was created to help stabilize the lives of homeless men and women, provide them with one type of protected environment and train them in the daily living skills they will need in order to live independently. Staff carefully supervises the process of finding an apartment and make many supportive visits after the individual is settled. Very often the person continues to attend the day program associated with Parker Street after he has his or her own place.

From a planning perspective the next logical step is the creation of a network of new facilities to provide protected housing, on a permanent basis, to those who require it. Other services, including day programs, should be developed to provide additional support to residents of these facilities. In the earlier days of our nation, many of the persons now homeless would be living with families if only because, in the words of Robert Frost, "Home is, when you go there, they have to take you in." We feel that every person, now homeless, no matter how incapacitated by mental or physical illness, deserves an opportunity to live in a stable residence where he or she will be made to feel more welcome than Frost's line implies. These should not be institutions in any sense of the word but rather facilities operated by organizations already familiar with the problems faced by homeless mentally ill or alcoholic persons.

The planning of a network of facilities which will provide permanent housing must include a strong human services component. However, the Executive Office for Communities and Development (EOCD), which already has responsibility for the planning and development of housing for other special groups of citizens, should have primary responsibility for this program. Therefore, we recommend that:

> The Executive Office of Communities and Development, after consultation with the Executive Office for Human Services, recommend to the Governor a plan for the creation of a network of protected housing facilities which would serve the special needs of homeless men and women. In developing this plan the EOCD should also consult with shelter directors and advocacy groups.

The directors of several of Boston's emergency accommodation shelters have suggested that the model which should be used for these facilities is the familiar rooming house or Single Room Occupancy (SRO) housing. In the South End, where many rooming houses have ceased to exist, those which still survive provide a certain amount of appropriate and affordable housing for persons who once lived in shelters. A report published in 1981 by the Massachusetts Association for Mental Health, The Beacon Chambers Hotel: The Fire and its Aftermath, emphasized the importance of an alert and sympathetic management to the stability of the men who stayed at the Beacon Chambers.

One of the components of the Governor's Advisory Committee on Homelessness is a subcommittee on SRO Housing. This Task Force has made a number of recommendations relating to tax abatements and tax incentives to encourage existing SRO's to continue in operation. We recommend that:

> The Executive Office of Communities and Development include the recommendations of the Subcommittee on SRO Housing as part of its legislative package in calendar year 1984.

In Boston and in other cities around Massachusetts, there are some rooming houses presently being operated by religious organizations on a non-profit or "breakeven" basis. Some shelter directors and directors of other private agencies have indicated to us that, because of the great need for this kind of housing they would be interested in exploring the possibility of acquiring and sponsoring operation of a local rooming house, especially one which might otherwise be going out of business. At this time there is no organized effort to encourage such agencies or church-related groups to develop such non-profit SRO's. Therefore we recommend that:

> As part of its more general effort to plan for a network of protected housing facilities the Executive Office of Communities and Development explore ways it can assist non-profit organizations already interested in acquiring or operating rooming houses or SRO housing.

There is an immediate need for more information about the current status of rooming houses in all parts of the Commonwealth. Our interviews in Lynn revealed that over fifty rooming houses operate in that city and provide housing for a substantial number of men and women who suffer from mental illness or alcoholism. We recommend that:

> The Executive Office of Communities and Development conduct a survey of rooming houses in all parts of the state. The Executive Office of Communities and Development should publish the results of this research in a directory which would be made available to shelters, churches and non-profit agencies as well as to the general public.

PART THREE
HOMELESS FAMILIES

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I. INTRODUCTION

The first part of this report described the existing system of transitional shelters currently serving families. We estimated that in the course of a year at least 1,600 families seek shelter either in Boston or in one of the adjacent cities where we conducted interviews. Approximately 500 families actually obtain shelter from existing programs. These figures led to our recommendation that at least six new transitional shelters, each accommodating six to ten families, be established in the Greater Boston area and that the existing transitional shelter system be strengthened and improved.

These recommendations were accompanied by a warning that the establishment of additional transitional shelters would be an entirely inadequate response by our community to the problem of family homelessness unless many other additional actions were also taken. This chapter is devoted to a discussion of these actions which include expansion of certain public welfare benefit programs; development of a "homesaving service" by the Department of Social Services; and development or expansion of several housing programs for homeless families.

We present these recommendations with a sense of urgency. Some have already been advocated by Task Forces associated with the Governor's Advisory Committee on the Homelessness. Others represent reforms in administrative regulation or traditional practice which have concerned shelter directors and staff for years. Still others are attempts to improve the available techniques for locating permanent housing for low-income persons in the private marketplace. In many cases, the first steps toward implementation of these recommendations could be taken immediately by the public and private agencies concerned.

II. CHARACTERISTICS OF FAMILIES WHO SEEK SHELTER

The census of February 25th, 1983, involving all Boston and Cambridge shelters, has been described in the introduction and in the previous section. Nine shelters reported a total of 44 families staying overnight. It should be noted that Project Hope, which ordinarily shelters six families, was in the process of repainting and, therefore, only one family was in residence on the night of the survey. Because of staff shortages, two family shelters (Casa Myrna Vasquez and Mary Lawson Forman House) were unable to provide us with information on the night of the survey.

A. Former Community of Residence

The transitional shelters which provide services for battered women and for other family groups collect exact information regarding the last previous address of their guests. Our interviews with shelter directors suggested that these shelters for the most part identified their guests as coming from nearby communities. Because battered women's shelters refer potential guests to each other in order to take advantage of available bed space, their service pattern showed more guests from cities geographically far removed. On the other hand, the general family shelters indicated that they saw relatively few families seeking help from other parts of the Greater Boston area.

Chart One, which displays the information obtained in the February 25th survey, supports the directors' contentions. Of the 44 families sheltered on that night, 32 (72.7%) came from some part of Boston while another four (9.0%) came from Cambridge. The remainder came from various locales scattered throughout the Greater Boston area.

CHART ONE

City or Town Most Recently Lived In

City or Town	Number of Families
Boston (no neighborhood)	13
Boston - Neighborhood	
Dorchester/Mattapan	10
Jamaica Plain	4
Roxbury	2
East Boston	1
Charlestown	1
Brighton	1
Boston Subtotal = 32	
Other	
Cambridge	4
Attleboro	1
Cape Cod	1
Chelsea	1
Lawrence	1
Lynn	1
Salem	1
Washington, DC	1
No response	1
Other Subtotal = 12	
TOTAL	44

Local informants in the five cities outside of Boston confirmed the implications of this finding. The United Way Information and Referral Office in Lynn indicated that "ten times as many" families came from Lynn than from other cities. In Quincy, an agency director who saw many homeless families indicated that she seldom saw a family who had not lived in Quincy at some time or was living in Quincy just before it became homeless.

Informants in these cities reported that, even though they knew of some shelters available in Boston, they did not refer families to them because Boston was regarded as an "alien" and "dangerous place." One agency head summarized these feelings by saying: "My family clients hear the word 'Boston' and they think of robbery, rape and murder. There is no way I am going to recommend a Boston shelter to them."

B. Composition and Age of Family Groups

The question of family composition is of vital importance in planning for the development of shelter programs for families. If large families are to be expected, fewer can be accommodated in a facility. The proportion of children who are too young to attend school and, therefore, will need child care is also significant.

In the survey of February 25th, we sought to shed light on these issues by asking for the age and sex of each person sheltered. The results are displayed in Charts Two through Four.

The major finding was that of the 44 families (134 persons), 37 (84.1%) were single-parent female-headed families. Only six adult males were included among those sheltered on the survey night. In part this is due to the fact that many transitional shelters serve only women and children while excluding adult males.

Forty (90.9%) of the 44 families included at least one child. In all there were 83 children and 51 adults in shelter. Almost half the children (41 of 83) were under the age of five years, and of these, ten were under a year old.

Of the 44 families, 24 (54.5%) were composed of a mother with one or two children. (This figure would have been higher if Project Hope had been fully operating at the time of the survey.) These figures suggest that in the Boston/Cambridge area families consisting of a mother with one or two children are the norm in shelters.

CHART TWO

Family Composition

Family Composition	Number of Cases
Mother with one child	14
Mother with two children	10
Mother with three children	9
Mother with four children	3
Mother, father, one child	1
Mother, father, three children	2
Couples with no children	3
Mother and daughter (both adults)	1
Three-generation family	1
TOTAL	44

CHART THREE

Ages of Adults in Families Reported Sheltered

Age	Males	Females	Total
18	0	3	3
19	1	2	3
20	0	2	2
21	0	0	0
22	1	2	3
23	1	5	6
24	0	4	4
25	0	4	4
26	1	1	2
28	0	2	2
29	0	1	1
30-34	0	9	9
35-39	1	7	8
40-49	0	3	3
50-59	1	0	1
TOTAL	6	45	51

CHART FOUR

Ages of Children Reported Sheltered

Age	Males	Females	Total
Less than a year	7	3	10
1 year	5	6	11
2 years	3	4	7
3 years	4	3	7
4 years	3	3	6
5 years	1	3	4
6 years	4	5	9
7 years	2	1	3
8 years	3	1	4
9 years	2	2	4
10 years	2	2	4
11 years	2	2	4
12 years	2	1	3
13 years	1	1	2
14 years	0	1	1
15 years	0	3	3
16 years	0	1	1
17 years	0	0	0
TOTAL	41	42	83

While no statistical information was available regarding the composition of families seeking shelter assistance from Brockton Catholic Charities, the North Shore CAP in Peabody, or the Southwest Community Center in Quincy, staff of these organizations stated that small single-parent families comprised a major proportion of their clientele. The younger mother, inexperienced at taking care of herself and additionally burdened with a child or two, was regarded as the type of person most vulnerable to becoming homeless.

III. DEVELOPMENT OF A "HOMESAVING SERVICE" FOR DEPARTMENT OF SOCIAL SERVICES CLIENT FAMILIES

Families who become homeless, whether they stay in one of the existing shelters or simply double up with neighbors, friends, or relatives, are exposed to extraordinary strains. When such families are already receiving service from the Commonwealth's Department of Social Services, case workers must assess the potential for child abuse or neglect resulting from the new situation. According to the shelter directors interviewed for this report, custody petitions are sometimes filed against homeless mothers. This finding is supported by a study,[1/] prepared by Mitchell and Bernstein of Meredith and Associates, which showed that eight of 61 families interviewed had children taken from them as a result of such custody petitions.

Mitchell and Bernstein go on to point out that the family automatically loses its eligibility for AFDC benefits after the child or children are removed. As a result, "the family has no hope of securing an immediate source of income through which they could obtain permanent housing."[2/]

Some families who become homeless file their own petitions with the Department of Social Services in order to have their children placed in foster care because they do not want to expose them to the rigors of living on the street. According to shelter directors, it is very difficult to get these children back from foster care even after the family has been resettled. Some also report that the Department of Public Welfare declares such families ineligible for Emergency Assistance after such a voluntary placement is made.

It should be added that the extent to which Department of Social Services staff uses "homelessness" alone as a criterion for removal of children is not known. Often there are many aspects to a "51A case," as these cases are called at the Department, and the issue of homelessness is only one factor. Nevertheless, this criterion suggests "homelessness" is viewed as a kind of stigma and has been brought on by the misbehavior of the adult family members.

1/ Dale Mitchell and Ronna Bernstein, Special Report: A Profile on Family Homelessness, Meredith Associates, 1983 p. 14.

2/ Ibid., p. 14.

These findings raise very serious issues relating to public policy. On the one hand, it is clearly the mission of the Department of Social Services to protect all children from potential abuse and neglect and to seek the removal of children from parents if that is necessary for their protection. On the other hand, children in homeless families are already undergoing a most traumatic experience which might well be made worse by separation from their parents.

A better strategy for the Department of Social Services would be to embark upon a policy of preventing episodes of homelessness by intervening vigorously with a "homesaving service" whenever it appears that a client family is in danger of becoming homeless. Staff of transitional shelters, as well as community workers who specialize in this field, have become adept at putting together "packages" including location of an apartment or room, a rent voucher from a private agency, or Emergency Assistance from the Department of Public Welfare. Other components may include special counseling for a family member or home health care for an ill parent. All of these techniques could be used to "save" a home.

A "homesaving service" requires skilled and highly motivated workers thoroughly knowledgeable about the availability of financial supports (including private funds) and specialized services throughout the community. Either by preventing an episode of homelessness or by moving rapidly to mitigate one, a case worker will, in the long run, provide a far more effective protective service than can be done by simply removing the children from the homeless situation. With this philosophy in mind, we recommend that:

> The Department of Social Services begin to develop a capacity to provide a "homesaving service" to client families who have become homeless or appear to be about to lose their homes. This service might be provided by specially trained DSS staff or by non-profit agencies contracting with the state agency.

IV. THE FINANCIAL RESOURCES OF HOMELESS FAMILIES

In our interviews with transitional shelter directors in Boston and Cambridge, we found some disagreement regarding the extent to which sheltered families relied upon public welfare benefits. While some directors reported that virtually all guests received such benefits, others indicated that a number of families were supported exclusively by employment income.

In the survey on the 25th, shelter staff were asked to specify if any member of each family was receiving public financial assistance. They were also asked: "Has an adult in this family been employed in the last three months?" The period of three months was used to identify cases in which a family member might have been laid off in the recent past.

Chart Five shows the answers to these questions. Approximately one-fifth of the families had at least one member employed during the previous three months, and five (11.4%) were entirely supported by these jobs.

Dependence upon public welfare benefits was total for 32 (72.7%) of the families. It is likely that the three families reported as receiving neither type of income would soon be obtaining Aid for Families with Dependent Children (AFDC) benefits.

CHART FIVE

Sources of Family Support

	Employed Within Last Three Months		Not Employed Within Last Three Months		Total	
Receiving Public Welfare	4	(9.1%)	32	(72.7%)	36	(81.8%)
Not receiving Public Welfare	5	(11.4%)	3	(6.8%)	8	(18.2%)
TOTAL	9	(20.5%)	35	(79.5%)	44	(100.0%)

These findings were supported by the study by Mitchell and Bernstein[5/] which found that 51 of 61 (83%) families were partially or completely dependent on welfare benefits.

3/ Ibid., p. 5.

At the agencies who care for homeless families in Lynn, Quincy and Salem, staff reported that most of their new cases were families in which mothers were already receiving AFDC. Because no specific survey material, similar to that for Boston/Cambridge, is currently available, therefore, no exact comparison can be made.

Because of this high level of dependence, it is understandable that reductions in AFDC benefits, or changes in eligibility requirements which eliminate families from the AFDC rolls, may very well bring families closer to the brink of homelessness or propel them over the edge. Changes in food stamp eligibility may, and reportedly often do, have the same effect.

It is illogical that the Department of Public Welfare should, on the one hand, dramatically reduce the income of some recipients while at the same time funding a program to support families faced with dire financial emergencies. It would seem that this contradiction could be avoided through the development of a program which would provide support, for a limited period of time, to families who for some reason face a reduction in benefits or in food stamps which will render them unable to pay their rent. The basic aim of such a program should be to ensure that AFDC recipient families will not lose permanent housing.

We recommend that:

> The Department of Public Welfare should begin to develop a program of financial support to families removed from the AFDC rolls or who have lost their eligibility for food stamps, and whose living situations, by virtue of these cuts, have become imperiled or precarious. If necessary, legislation should be prepared and filed by the Department to authorize such payments.

V. EXPANSION OF THE EMERGENCY ASSISTANCE PROGRAM

Half the costs of Emergency Assistance programs are paid by the federal government. These programs provide for shelter and utility arrearages, repair of major home appliances, relief to fire victims, and temporary emergency shelter to eligible families for thirty days. Families with children who meet AFDC financial criteria are eligible whether or not they have been AFDC recipients.

However, there are various limits on the amount of money available to any particular family as well as the eligibility of families. The Task Force on Cash Assistance and Supportive Services of the Governor's Advisory Committee on Homelessness prepared a study which pointed out that the Department of Public Welfare had revised many Emergency Assistance regulations, but that some which remained were unrealistic. Among the concerns which were mentioned was the fact that a family might apply for emergency assistance only once in a 12-month period.

Our series of interviews, the report of the Task Force on Cash Assistance and Supportive Services and the Mitchell and Bernstein report all tended in the same direction. The policies of the Department of Public Welfare could do much to prevent family homelessness. To the greatest extent possible, the department should be urged to continue and accelerate its present course which seems to be to evolve policies which will lead toward this goal.

As an example of progress which has been made the Department changed its regulations in the fall of 1983 to allow a family to receive temporary housing in a hotel or motel for sixty days rather than thirty. This action responded affirmatively to one of the major concerns of advocacy groups. To continue this pattern we recommend that:

> If a family becomes homeless it should be eligible for sixty days of emergency shelter even if it has received some other Emergency Assistance component during the preceding twelve months.

Shelter directors, information and referral workers and advocates for homeless families repeatedly pointed out that the Department of Public Welfare staff have no responsibility to assist homeless recipients of Emergency Assistance who are seeking new housing. The comment was often made that, to the extent this reflected a deliberate policy of the Department, it appeared counter-productive since successful placement of Emergency Assistance recipients in new apartments would reduce the use of hotels or motels and hence the cost of the program. Therefore, we recommend that:

> The Central Office of the Department of Public Welfare should develop in two locations an experimental program of Housing Counseling for families receiving emergency shelter. The aim of this program should be to provide assistance to the families in seeking and obtaining new housing. One of these programs should be based in some neighborhood of Boston, the other in another Massachusetts city. The Housing Counseling should be provided by non-profit agencies familiar with the local housing supply.

VI. RESETTLING HOMELESS FAMILIES

A. The Term "Resettlement"

The term "resettlement" is used by those working with refugees to describe the process through which persons from Southeast Asia, Latin America, or other locations not only find a place to live but obtain assistance in "settling" into the life of a new nation. While homeless families are not forced to undergo the severe cultural shocks faced by refugees, their process of resettlement nonetheless often requires far more than simply finding homes. For most families, the goal of the resettlement process is to find a way of living independently in a room, an apartment, or a house where one has a legal right to stay.

Those who try to assist in the resettlement of homeless families must almost always work within the narrow constraints of limited income and a limited supply of housing. A resettlement worker will usually seek, first of all, to ascertain just how much income the family obtains, from what sources it comes and how steady it is. If possible, the resettlement worker will try to find ways to increase the flow of regular income. The search for housing is then strictly limited to those places the individual can afford.

The decline in the quality and quantity of housing stock actually available for poor people is not simply a phenomenon seen in Greater Boston, but one reported throughout the nation. For a complex of reasons, it has become less and less profitable for developers, landlords, or public agencies to plan and build housing which can be sold or rented cheaply. As new units are not being constructed, and some of the old units are converted to condominiums, burned down or simply razed, the competition increases for the units which are left.

The result, in the Greater Boston area and in many other parts of the nation, has been a rapid escalation in rental costs, even for apartments and rooms which are considered undesirable or unattractive. A recent report of the Ways and Means Committee of the Massachuetts Senate indicated that "the majority of households earning less than $15,000 a year in major urban areas are spending more than 25% of their income on housing -- while in Boston, Cambridge, Springfield, and Worcester, 40% of such families were spending 35% or more on shelter."[4/]

4/ "Homelessness", Report of the Senate Committee on Ways and Means, Senate 2100, June, 1983, p. 4-333.

Mitchell and Bernstein quote even more dramatic figures from their study of 61 homeless families interviewed in all parts of the state. They found that "while the 61 families' total shelter payments averaged only $275 a month, immediately preceding their homelessness these costs consumed fully 87% of their average monthly income."[5/]

Of these families, all but ten were receiving AFDC benefits or some other type of public welfare. The ten who were not, however, were significantly worse off since they received an average monthly income of only $175, "largely through panhandling, child support payments, and unemployment compensation."[6/]

B. Searching for Family Housing

Interviews with directors of transitional shelters revealed that a very small minority of homeless families manage to obtain an apartment in public housing projects either in Boston or in the suburbs. One shelter, with a large staff, routinely has a worker call the Boston Housing Authority every day "without fail" to check on the status of every guest who had made application. Despite this extraordinary effort, only 19 of 134 families housed in this shelter in 1982 obtained a BHA apartment.

Because public housing takes so few families, shelter directors have come to see the private housing market as "the only answer" for most of their guests. Given the limitations imposed by the small stock of affordable housing units, it is hardly surprising that shelter directors discussed the search for housing as the most difficult and frustrating aspect of their jobs. When asked what techniques were the most effective in finding housing, several directors replied "persistence" or "just sticking to it." Others said they worked to build up a certain amount of credibility with a small number of landlords and rental agents over a long period of time. They added that if even one family misbehaved or refused to pay rent after being accepted for an apartment, they would lose that contact.

5/ Mitchell and Bernstein, op. cit., p. 3.

6/ Ibid.

The transitional shelters have developed certain techniques for preparing guests for the housing search. One of these is to teach the guests how to respond to questions landlords might ask about sources of income, numbers of children, and personal background. Another is to insist that each guest open a savings account so that they would have some money available when an apartment was found. Some shelters hold weekly meetings which deal exclusively with housing issues.

One ingenious community worker has developed an unusual method of locating vacant apartments. Rather than relying on the local paper, he has recruited a "network" of "vacant-apartment spotters" including mailmen, oil dealers, and delivery truck drivers who pass the word along when a family moves out. He then moves quickly by "matching" the apartment with a family needing a place to stay.

For obvious reasons, virtually all shelter directors emphasized the desirability of increasing the number of housing units which might be available to persons of low income. In Boston, and in some of the cities outside of Boston as well, there are many abandoned buildings, some taken by the municipality for nonpayment of taxes, some of doubtful ownership. The directors often suggested that these buildings be turned somehow to the use of homeless families or individuals. In similar fashion, they suggested that schools, nursing homes and hospitals no longer operating, had potential use either as shelters or as sites for permanent housing.

As a result of discussions with community workers and advocates concerned with the issue, it became clear that there was no systematic way of searching for such buildings. There is no roster of potential locations for either housing or shelters where basic information about buildings such as size, type of heating system, state of repair, zoning status, present ownership, etc., is available. This being the case, we recommend that:

> The Executive Office for Communities and Development should develop a central repository of information regarding buildings which might be used for permanent housing or for shelters. This roster should not be limited to state-owned buildings but should include buildings owned by municipalities, nonprofit groups and private owners.

C. Facilitating the Resettlement Process

Shelter directors and others indicated that there were some specific steps which might be taken to ameliorate the difficulties sheltered families face while searching for housing.

Shelter directors were unanimous in stating that rent subsidy programs should be expanded and that homeless families should be given an especially high priority. Unfortunately, the Federal government appears to be moving strongly in the other direction by reducing the number of subsidies and strictly limiting eligibility requirements.

Increasing the state-funded Chapter 707 rental assistance program appears to be the only feasible way of assuring an increase in the availability of rent subsidies at this time. This program is funded through local housing authorities. The Housing Task Force of the Governor's Advisory Committee on Homelessness has recommended that use of these funds be made more flexible; that housing authorities be urged to use the program in conjunction with Chapter 689 (handicapped housing) projects and with SRO's; and that income levels for participation in the program be raised. We recommend that:

> The Executive Office for Communities and Development should consider favorably the recommendations of the Housing Task Force insofar as they can be implemented under current law and that additional amendatory legislation be filed if needed.

Because the current rental market is so tight, landlords are asking for and obtaining "security deposits" from persons who want to rent an apartment. These deposits amount to one or two months rent and represent a serious problem both to homeless families who are asked for them and to the shelter staff who try to raise the money quickly. One shelter staff member told us he had been asked for $900 to "secure" an apartment, another had been asked for $1,000. Some shelters have obtained private funds which they loan to guests for security deposits. Others have informal agreements with local churches who "cover" security deposits. Several shelter directors suggested that some type of central fund be initiated which would serve as a pool from which funds could be drawn to cover security deposits, moving expenses, etc. Thus, we recommend that:

> Sheltering programs and advocacy groups should explore the possibility of creating a fund for security deposits which would be administered by an agency familiar with the field. Funds to support such a program might be raised from the private sector.

VII. EXPANSION AND TARGETING OF HOUSING COUNSELING PROGRAMS

"They just don't want children. Even a mother with a single child is difficult to place. Finding housing for a woman with four or five children ... that takes a miracle."

This comment from the director of a shelter for abused women was repeated by shelter directors both in Boston and in adjoining cities. We were told of many incidents in which landlords flatly refused to rent to single women with children, even if she had adequate funds to cover the cost of the apartment. Some landlords made no secret of the fact that they chose only "appropriate" tenants and that the "inappropriate" included women receiving AFDC, black or Hispanic families and, often, any families including young children.

Yet the picture is not entirely bleak. At one transitional shelter, two families were preparing to move into a nearby building at the time of our interview. The director stated: "That man (the owner) does not have much money, but he came in here and told me he wanted to do something for some of our guests. He offered us two apartments he just rehabilitated. This kind of thing has happened several times since I have been here. In finding housing we are dependent on the help of the local landlords who often are not really much better off than the people who stay here."

The transitional shelters which serve families make an intensive effort to help their guests find new housing, generally in the private market. Given all the barriers in their way, it is remarkable that they succeed in as many cases as they do. Some shelters have established a policy that no family will be required to leave until a satisfactory housing plan for the family has been worked out.

The process of resettling guests would be greatly facilitated if an adequate housing counseling program was developed which would serve all the shelters of the Greater Boston area. A Housing Counseling program includes such services as checking newspaper advertisements; telephoning landlords; real estate agents or housing authorities on behalf of guests; accompanying guests on trips to view apartments; and seeking funds to cover security deposits.

Housing Counseling services are often delivered in conjunction with other more traditional counseling services. Interviews with shelter directors and with families at the Shattuck Shelter have indicated that most families need supportive counseling and that some family members need therapeutic counseling as well.

In the budget submitted for Fiscal Year 1984, the Dukakis administration requested one million dollars to fund housing counseling programs throughout the state. The Legislature removed these funds before the budget was passed. It is hoped that this request will be renewed in the fiscal year 1985 budget and that the Legislature will fund the request.

Even without this funding, however, a good deal could be done to lay the foundations for a housing counseling program to serve homeless families in the Greater Boston area. The Information and Referral Office of the United Way of Massachusetts Bay currently serves as the Greater Boston "hotline" which may be called by homeless persons and families seeking help. However, the United Way does not have sufficient staff to allow it to perform the normal activities of a housing counseling service. Indeed, it would probably be inappropriate for the Information and Referral Office to play this role directly. Nevertheless, volunteer leadership and staff of this office are deeply concerned about housing issues and anxious to provide linkages to available housing counseling service. Therefore, we recommend that:

> The Executive Office of Communities and Development should initiate meetings with the staff and volunteer leadership of the Information and Referral Office of United Way, together with representatives of local shelters and advocacy groups, to discuss the possibility of creating a housing counseling program as an adjunct to the existing Information and Referral program.

VIII. CHANGING HOUSING AUTHORITY REGULATIONS REGARDING EMERGENCIES

In the course of our interviews in Boston and in other cities, there was much discussion of the role of local housing authorities. The housing authority was often seen as a distant and somewhat alien organization which does not feel it has responsibility to relieve the plight of the homeless. Yet, this attitude was usually combined with an understanding that every local housing authority is under tremendous pressure to accept poor families and elderly persons who are recommended by all sorts of community organizations and agencies. One worker in an agency outside of Boston said, "I got 28 homeless families into the projects last year, but I didn't feel good about it. It meant that 28 other families, equally hard up, didn't get a place to live."

At the present time, local housing authorities place families and individuals on the "emergency list" only if they have been dishoused because of a fire or other natural disaster; if they have been evicted through a court order; or if a health inspector deems the building they are living in unsafe. Those on the emergency list may have to wait six months before being offered an apartment, but this is preferable to the usual two to three years wait for a family apartment in Boston and other cities.

The definition of "emergency" does not include "fleeing from domestic violence" or any other phrase which would make battered women eligible for the emergency list. This greatly concerns the directors of these shelters. As one said, "If your life is in danger, why can't you get emergency shelter?" The fact that other community organizations have tended to use the local housing authority's restricted definition of "emergency" in establishing eligibility for other types of emergency services has added to the dissatisfaction felt by these directors.

In response, housing authorities state that making battered women eligible for the emergency lists would only increase the already high level of community dissatisfaction with the long waits which families on the emergency lists must currently undergo.

This raises a number of complex administrative and legal issues. Many question the very existence of an "emergency list" which requires a wait of six months. Rather than recommend immediate sweeping changes in local housing authority practice, we recommend that:

> The Executive Office of Communities and Development, in consultation with various advocacy groups including the Coalition of Battered Women's Service Groups, and representatives of local housing authorities, should evaluate the definition of "emergency" now being used by local housing authorities and develop a broader one which is more in line with current social philosophy regarding the nature of housing emergencies. This re-evaluation might consider the possibility of alternatives to the current "emergency list" response to such housing emergencies.

IX. CONCLUSIONS

A 1979 report on emergency housing for homeless families in Boston pointed out that:

> When a natural disaster sweeps away many houses at the same time all the social, medical and humanitarian services of that community are mobilized to help the victims. In this report we have discussed homeless families whose lives have been uprooted and changed by individual and idiosyncratic events which do not have the dramatic potential of a tornado, flood or blizzard. These events do not motivate the community to bring together its resources so that each family may be helped in turn. This task is left to the churches and neighborhood-based agencies who "take care of their own" as best they can.7/

To a large extent these words remain true today. However, the creation of such organizations as the Massachusetts Coalition for the Homeless and the Governor's Advisory Committee on Homelessness may be seen as indications that our community is at last beginning to mobilize its resources to meet the immediate and long-range needs of homeless families, and individuals. The recommendations made in this report represent an effort to enhance our community's ability to meet the manifold problems of the homeless.

7/ Paul McGerigle, Paul Hunt and Susan White, Management of Family Housing Crisis in the City of Boston, United Community Planning Corporation, Boston, Massachusetts, November 1979, page 40.

APPENDICES

APPENDIX A

LIST OF INFORMANTS

SHELTER DIRECTORS AND STAFF -- BOSTON AND CAMBRIDGE

Name	Shelter
Cathy Barber	Transition House
Sidney Beckford	Salvation Army-Roxbury Corps Center
Dorothy Bedell	CASPAR Emergency Service Center
Sandra Bensford	Salvation Army-Harborlights
Eileen Brigandi	Rosie's Place
Marvin Byrd	Boston Family Shelter
Brenda Cotter	Elizabeth Stone House
Barbara Davidson	Parker Street Shelter
Elizabeth Ellis-Hagler	Renewal House
Clara Garcia	Casa Myrna Vasquez/Mary Lawson Forman House
Arlene Glasser	Parker Street Shelter
Dorothy Hill	Sojourner House
Margaret Kennedy	Sancta Maria
Madelaine McGowan	Temporary Home for Women and Children
Ann McHugh	Lemuel Shattuck Shelter
Father Robert McMillan	Commonlife
Pat Murphy	Pine Street Inn
Richard Ring	Pine Street Inn
Paul Robinson	Long Island Shelter
Sister Theresa	Project Hope
David Whitty	Shelter, Inc.
Pam Winsor	Pine Street Inn

SHELTER DIRECTORS AND STAFF -- OTHER COMMUNITIES

Susan Beck	DOVE-Quincy
Robin Braverman	Waltham Battered Womens Support Committee
Maureen Kelly	Womensplace Brockton
Ann Mally	HAWC-Salem
Sister Kathy McGuire	Lewisohn House-Brockton
Bonnie Wolf	Respond-Somerville

Appendix A (Continued)

MENTAL HEALTH AGENCY STAFF -- BOSTON AND CAMBRIDGE

Name	Agency
Ron Addison	Solomon Carter Fuller Center
Katie Blake	Solomon Carter Fuller Center
Eileen Crowley	Tufts Bay Cove
Alvira Donatelli	Solomon Carter Fuller Center
Jane Eckert	Lindemann Mental Health Center
Sandy Felder	Lindemann Mental Health Center
Jim Galvin	Tufts Bay Cove
Sondra Hellman	Massachusetts Mental Health Center
Laurie Jannen	Cambridge Somerville Mental Health Center
Susan Luckman	Dorchester Counseling Center
Joan McElaney	Tufts Bay Cove
John Moore	Solomon Carter Fuller Center
Bill Salton	Cambridge Somerville Mental Health Center
Carol Seval-Brooks	West-Ros-Park Mental Health Center
Ellen Sinnott	Cambridge City Hospital
Elizabeth Spencer	Cambridge Somerville Mental Health Center
June Tammi	Solomon Carter Fuller Center
Brian Toomey	Lindemann Mental Health Center
Noreen Webber	West-Ros-Park Mental Health Center

MENTAL HEALTH AGENCY STAFF -- OTHER COMMUNITIES

Linda Achber	Metropolitan Beaverbrook Mental Health Center-Waltham
Dr. Susan Bereika	Medfield State Hospital-Quincy
Maureen Doyle	South Shore Mental Health Center-Quincy
Audrey Young	Lynn Area Office-DMH

OTHER INFORMANTS -- BOSTON AND CAMBRIDGE

Name	Agency
Ruth Aiken	Boston State Area Office-DSS
Jane Alexander	Women's Lunch Program
Richard Allen	Greater Boston Legal Services
Shirley Bean	Homeless Hotline-Parents and Children's Services

Appendix A (Continued)

Name	Agency
Pauline Bonnanno	St. James Church
Frank Bulger	Boston Detoxification Center
Rev. Louis Canino	St. Anthony's Shrine
Cindy Chin	Mass Coalition Battered Women's Service Groups
Arthur Clark	Kenmore Detoxification Center
Eleanor Clark	Social Services -Mass General Hospital
Phyllis Cogswell	Emergency Room - Boston City Hospital
Bob Conway	Andrew Johnson Detoxification Center
Linda DeBoer	Social Services-Brigham & Women's Hospital
Mary Donaldson	Social Services-St. Elizabeth's Hospital
Michael B. Donham	The Center House, Inc.
Jo Ann Eccher	Project Bread Hunger Hotline
Jan Eustis	Tufts Bay Cove Area Office-DSS
Barbara Ferrer	Family Service Association of Greater Boston
Elaine Fersh	Boston Housing Authority
Rev. Louise Forrest	Old West Church Drop In Center
Milton Friesen	Kingston House
John Gardner	Roxbury Crossing Office-DSS
Marian Glazer	Greater Boston Legal Services
Anne Goldenberg	United Way Information and Referral
Mary Gray	Social Services-Carney Hospital
Ruth Hibma	Ruggles St. Baptist Church
Rev. Emmett Jarrett	Church of St. John the Evangelist
Carol Johnson	Massachusetts Coalition for the Homeless
Leonore Jones	Disaster Service-Boston Chapter-American Red Cross
Mary Ann Jurkiewicz	River Street Detoxification Center
Gary Kaplan	Project Place
Rev. Brian Kelly	St. Paul's Cathedral
Liz Kreilkamp	Project Place Drop In Center
John Kwarciany	Disaster Service-Boston Chapter-American Red Cross
Valerie Lanier	Mayor's Office of Emergency Shelter

Appendix A (Continued)

Name	Agency
Rev. John Lavin	Mission Church
Charles Liddell	Travelers Aid Society
Virginia McCarthy	Family Service Association of Greater Boston
Rev. Michael McGarry	Paulist Center
Donna Makin	Region VI - DSS
Betty Morrison	Cambridge Council of Elders
Tim Overton	Back Bay Council on Aging
Suzanne Palma	Harbor Area Office-DSS
Sue Parry	Mayor's Commission on the Elderly
Linda Roeder	Cambridge Somerville Home Care
Al Smith	Boston University Area Office-DSS
Jane Smithers	Dept. of Sociology-Boston University
Maureen Snorozykski	Emergency Room-University Hospital
Richard Sorricelli	Travelers Aid Society
Joseph Valleley	Archdiocesan Planning Office
Janet Van Zandt	Women's Educational and Industrial Union
Margaret Venator	Pilgrim United Church of Christ
James Viola	Kenmore Detoxification Center
Michael Whalen	Sojourner House
Kristin Winbogler	Outpatient Services-New England Medical Center

OTHER INFORMANTS -- OTHER COMMUNITIES

Name	Agency
Mary Brelsford	Southwest Community Center-Quincy
Ginny Comeau	Salvation Army-Lynn
Pat Conway	Catholic Charities-Brockton
Marcia Countie	United Way Information & Referral-Lynn
Iris Cramer	Discharge Planner-Waltham Hospital
Alma DeVine	St. Paul's Church-Brockton
Elizabeth Donovan	North Shore CAP-Salem/Peabody
Sharon Ellis	Community Health Center-Lynn
Ellie Giannini	Waltham Office-DSS
Jane Holappa	North Shore CAP-Salem/Peabody

Appendix A (Continued)

Name	Agency
Robert Hughes	Bristol Lodge-Waltham
Frank Kearney	My Brother's Table-Lynn
Joyce Kidney	North Shore CAP-Salem/Peabody
Mary Jane Lee	Citizens for Adequate Housing-Salem/Peabody
Father William McCarthy	St. John's Church-Quincy
Robert Martin	Mayor's Office of Human Services-Brockton
Neil Michaels	Waltham Office-DSS
Rev. Chuck Navel	Crombie St. Church-Salem
Mary Prendergast	Waltham Office-DPW
Elaine Reiser	Brockton Area Helpline
Jack Robinson	Lynn Economic Opportunity Inc.
Esther Sanger	Quincy Crisis Center
Rosemary Wahlberg	Quincy Community Action
Kathy Walsh	North Shore Catholic Charities-Salem/Peabody

APPENDIX B

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